EXHIBIT A

IN THE SUPERIOR COURT OF NEW JERSEY

LAW DIVISION - BERGEN COUNTY

CIVIL ACTION

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KATHRYN E. CORBET and ERIC R. CORBET Plaintiffs, v.	:	DOCKET NO. BER-L-14589-14 MCL
ETHICON, INC., ETHICON WOMEN'S HEALTH AND UROLGY, a Division of Ethicon, Inc., GYNECARE, JOHNSON & JOHNSON, AND JOHN DOES 1-20 Defendants.	:	MASTER DOCKET NO. BER-L-11575-14

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NOVEMBER 24, 2015

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Videotape deposition of NICOLE FLEISCHMANN, M.D., taken pursuant to notice, was held at the law offices of Riker Danzig Scherer Hyland & Perretti, LLP, 500 Fifth Avenue, 49th Floor, New York, New York 10110, commencing at 9:34 a.m., on the above date, before Amanda Dee Maslynsky-Miller, a Certified Realtime Reporter and Notary Public in and for the State of New York.

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ALSO PRESENT: Henry Marte, Videographer

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(It is hereby stipulated and agreed by and among counsel that sealing, filing and certification are waived; and that all objections, except as to the form of the question, will be reserved until the time of trial.)

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VIDEO TECHNICIAN: We are now on the record. My name is Henry Marte. I am an videographer for Golkow Technologies. Today's date is November 24th, 2015, and the time is 9:34 a.m. This videotape deposition is being held at 500 Fifth Avenue, New York, New York, taken in the matter of Corbet versus Ethicon, Inc., filed in the Superior Court of New Jersey, Law Division, Bergen County.

The deponent is Dr. Nicole Fleischmann. Counsel will be noted on the stenographic record. The court reporter is Amanda Miller and will now swear in the witness.

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NICOLE FLEISCHMANN, M.D., after having been duly sworn, was examined and testified as follows:

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EXAMINATION

- - -

BY MR. SLATER:

Q. Good morning, Dr. Fleischmann.

A. Good morning.

Q. I'm Adam Slater. I'm here to take your deposition today. You understand that's why we're here, right?

A. Yes.

Q. You understand you have to tell the truth in response to all my questions?

A. Yes.

Q. If I ask you a question that doesn't make sense to you for some reason; for example, I may mispronounce medical terminology or I may ask a question where it just doesn't make sense, for whatever reason, just tell me, tell me what's unclear and I'll try to re-ask the question.

A. Okay.

Q. Counsel may object to questions. If they do, they'll just say objection. And then you'll answer, unless something happens that I've never seen before. But who knows?

They are allowed to place objections, they're doing that to preserve their rights for the future. So if they do it, just answer the question after they object, okay?

A. Okay.

Q. And at the end of the deposition, if they question you, give me a chance to object to their questions, because I may do that, too. All right?

A. Okay.

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(Whereupon, Exhibit Fleischmann-1, Notice of Deposition, was marked for identification.)

- - -

BY MR. SLATER:

Q. We've marked as Exhibit-1 to your deposition the notice for deposition.

Have you seen that before?

A. Yes, I have.

Q. One of the questions I have is whether or not you have any, or have had in the past, any consulting agreements with Ethicon?

A. Consulting agreements in terms of being a proctor or preceptor, yes.

Q. How many times did you enter into consulting agreements?

A. It was over the course of a four- or five-year period.

Q. What four- to five-year period?

A. 2000 and -- I'm really guessing, to be honest. Somewhere about 2005 and 2010, I would say.

Q. When did you last have a contractual relationship with Ethicon of any nature?

A. Again, I'm guessing. But I believe it was about 2010, maybe 2011.

Q. You're giving me your best estimate, right?

A. Exactly.

Q. Okay. How much total money did Ethicon pay you over the years?

A. It was not a tremendous amount. I think I've seen in the record it was about $10,000 over five years.

Q. How much -- rephrase.

Are you able to estimate the benefits they gave to you or gave on your behalf, for example, airfare or meals or anything like that, or rides to places? They did those things, too, right?

A. Probably, all said and done, under $200.

Q. You've had under $200 in meals from

Ethicon over the years?
A. If that. I don't remember ever eating any meals on Ethicon.
Q. Okay.
A. Unless -- I can't remember if we ever had a dinner or something that involved a meal.
Q. You can't remember if you ever had a dinner where Ethicon brought you to dinner with other doctors and paid for it? Is it hard -- you don't remember that?
A. If it happened, maybe it happened once. I don't -- yeah, I don't recall. I'll be honest.
Q. Didn't you review e-mails and documents that showed you having dinners where Ethicon took you out to dinner? Didn't you review that before the deposition?
A. I don't recall any e-mails or documents where I was taken out to dinner by Ethicon. I did review e-mails, but I don't recall any of those.
Q. Okay. Who at Ethicon have you had a relationship with over the years? Tell me the names of the people that you've worked with there.
A. Currently, I don't have any

relationship with anyone from Ethicon. I would say that I do remember some of my reps over the years.
MR. SLATER: Move to strike.
BY MR. SLATER:
Q. Doctor, if I ask you a question, I'd rather you not tell me about what you don't -- about something else I didn't ask you about. So it's a very direct question.
Who at Ethicon can you name that you have worked with in the past?
MS. KABBASH: Objection.
THE WITNESS: I remember General was my rep, I'm blanking on his last name. I remember my original Ethicon rep was Jeff Potkul. And there may have been some other reps in there that I just don't recall their names.
BY MR. SLATER:
Q. Anybody else at Ethicon you ever worked with?
A. I had some exchanges with Scott Jones over the years. But -- maybe Melissa Doyle.
Q. Anybody else?
A. Not that I recall.
Q. Melissa Doyle, what was her role, to your knowledge?

A. She was someone in prof/ed and marketing.
Q. What was your interaction with Melissa Doyle from professional education/marketing?
A. I had gone to a couple of pelvic floor meetings where she was running the meeting.
Q. Pelvic floor meetings, who was attending those meetings?
A. Other physicians who were doing Ethicon products, who they were asking for our feedback about the products and their use.
Q. Were you paid to attend those meetings?
A. Yes.
Q. How much were you paid?
A. I believe, maybe, $1,000 for a meeting.
Q. When did those meetings take place?
A. Actually, I want to retract that. I don't think I was paid for those meetings. I don't think I was paid for those meetings.
Q. Where did the meetings take place?
A. I don't remember.
Q. New Jersey? New York?
A. There was one in New Jersey. I went

to a couple, two total. And I think one was in New Jersey, and I can't remember where the other one was. I remember traveling somewhere.
Q. Traveling by car or traveling by airplane? Or train or bus?
A. I think by car. But I can't remember. I'm being honest. It was a while ago.
Q. I appreciate you're being honest. I'll assume you will be honest today.
A. I don't remember where the meetings took place.
Q. You understand that you have to be honest today?
A. I do. I try to be.
Q. Scott Jones, what was his role?
A. Also a liaison in the -- in the marketing area. And he would attend those meetings as well. That's how I remember his name.
Q. Do you consider yourself, when you were working with Ethicon, to be helping them with their marketing?
A. No.
Q. Do you know that they considered you to be helping them with their marketing?
A. Perhaps.

Q. Did you understand, when you were working with Ethicon, that they saw you as someone who could help them to market their products?
MS. KABBASH: Objection.
THE WITNESS: I never saw it as that. I saw that they were asking our feedback to help understand how we can better the products.
BY MR. SLATER:
Q. Were there times that you spoke to other physicians on behalf of Ethicon?
A. No.
MS. KABBASH: Objection.
BY MR. SLATER:
Q. You never did preceptorship or a proctorship?
A. Oh, sure. I did -- I did a couple preceptorships and proctorships.
Q. And when you were in those events, you spoke to other doctors, right?
A. I was teaching other doctors how to use the products.
Q. Did you understand that one of the purposes of that event, from Ethicon's perspective, was to help get those doctors interested in using the products and, thereby, increasing sales? Did

you understand that was one purpose, from Ethicon's perspective?
A. I don't know what Ethicon's perspective was in that.
Q. Well, that was the question.
You didn't know?
A. I don't know. I know what my perspective was.
Q. Didn't you ask you your perspective.
So let's try it again.
A. Sure.
Q. When you were a preceptor or proctor, did you understand that one of the purposes of that event, from Ethicon's perspective, was to interest doctors in their product and help increase sales? Did you understand that Ethicon that purpose in mind?
A. I can't speak to what Ethicon's purpose was.
Q. Did you ever consider marketing of Ethicon products to other doctors in any of the time that you interacting with Ethicon? Was that ever something that you considered?
A. No.
MS. KABBASH: Objection.

BY MR. SLATER:
Q. Did Ethicon help you advertise your services to patients?
A. No.
Q. Did they ever talk to you -- rephrase.
Did Ethicon ever contact you and discuss with you, in some way, the possibility they could help to bring patients to your office?
A. If they did, I don't recall.
Q. Jeff Potkul, you said, was your original sales representative?
A. Yes.
Q. Do you have any sense of what the time period was?
A. Probably about 2007 or '06.
Q. You said someone named General something was another sales?
A. General Butler. I just remembered his last name.
Q. General Butler was your sales representative during what period of time?
A. After -- after Jeff had left.
Q. So after 2007 or around then?
A. Probably around 2010 or '11.

Q. Who is your current sales representative from Ethicon?
A. I don't know. I haven't seen a representative from Ethicon in a long time.
Q. Really?
A. Really.
Q. Do you use the TVTTM Retropubic device currently?
A. Not currently.
Q. When did you stop using the TVTTM Retropubic device?
A. I used the last TVTTM Retropubic device, probably, in 2007. Well, that's not true. I had done TVTTM Retropubic over the years, but very rarely. I would say my majority of retropubic devices before 2007.
Q. You -- I think I read in your report that you started with the TVT in about 2002?
A. Right.
Q. And you used it with decreasing frequency up until 2007?
A. Yes.
Q. And after 2007, you don't use it anymore?
A. I use -- I've used it sporadically

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over the years. Maybe one or -- a couple a year. But now I do more -- if I'm going to do a retropubic, I do the TVT EXACT®.

Q. When is the last time you put a TVTTM Retropubic in a woman's body?

A. I don't know the exact date. But probably about 2011 or '12, I would say.

Q. When you make a recommendation to a patient for various surgical options, you weigh risks and benefits, correct?

A. Yes.

Q. And when you recommend a mesh device system, you weigh the risks and benefits of that mesh device system as opposed to the other alternatives available, correct?

A. Yes.

Q. And there came a point, around 2007, where your risk/benefit analysis led you to recommend the TVT EXACT® at that point going forward in virtually every case, as opposed to the TVTTM Retropubic where those would be two options, correct?

MS. KABBASH: Objection.

THE WITNESS: No.

BY MR. SLATER:

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Q. Let me ask you this: There came a point when you started to use the TVT EXACT® instead of the TVTTM Retropubic, correct?

A. Yes.

Q. You did that because you felt there were certain advantages to the EXACT® as compared to the Retropubic, correct?

A. Not specifically.

Q. So you just randomly chose to use another device that you thought was no better than the one that you stopped using and that you were used to using just because you felt like it or was -- there was no good reason for it?

MS. KABBASH: Objection.

THE WITNESS: I didn't start using it because I thought it was much better than the TVTTM Retropubic. I thought the TVTTM Retropubic was a good device. I just liked the TVT EXACT®® as well.

BY MR. SLATER:

Q. You liked the TVT EXACT®® better than the TVTTM Retropubic, that's why you switched to the EXACT®, correct?

MS. KABBASH: Objection.

THE WITNESS: No. I liked the trocars of the TVT EXACT®®; they were a little

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thinner and a little easier for me to use. But the actual device, the TVT, is exactly the same.

BY MR. SLATER:

Q. Is the mesh load for the TVTTM Retropubic the same as for TVT EXACT®®?

MS. KABBASH: Objection.

THE WITNESS: In my mind, it is, yes.

BY MR. SLATER:

Q. Well, "in your mind," what does that mean?

A. I've seen no difference in clinical outcomes between TVT EXACT®® and TVTTM Retropubic.

MR. SLATER: Move to strike.

BY MR. SLATER:

Q. Is it the same amount of mesh in the TVTTM Retropubic versus the TVT EXACT®®?

A. Yes.

Q. Exactly the same amount of mesh?

A. Yes.

Q. It's no shorter?

A. No, it's no shorter. We put the same amount of mesh in the patient in the TVT EXACT®® as in the TVTTM Retropubic.

Q. And what is the difference between the TVT EXACT®® and the TVTTM Retropubic?

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A. Only, in my mind, is the trocars and the size of the trocars.

Q. Are there any other differences between the systems?

A. Well, there are mild variations in how you place the sling. But these are not advantages or disadvantages, in my mind. What you're leaving in the patient's body is the same.

Q. If it's placed differently, is it tensioned differently?

A. No, it's not. It tensioned exactly the same.

Q. Does Ethicon market the TVT EXACT®® as having certain advantages over the TVTTM Retropubic?

A. I don't know.

Q. Are there any other mid-urethral slings from Ethicon that you have used in your career?

A. Yes.

Q. What?

A. The TVT Obturator sling.

Q. Do you use that currently?

A. Yes.

Q. If you had to tell me a breakdown

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between TVT Obturator and TVT EXACT®® in your current practice, how would you break that down?
A. I would say the majority of the patients is TVT Obturator. And I would say that that number is close to 90 percent.
Q. When did you start using the TVT Obturator?
A. I started using it in my fellowship, which was in 2004.
Q. Once the TVT Obturator became available to you, did you shift to using that in virtually all cases where you were going to put a mid-urethral sling in as compared to the Retropubic?
A. No.
Q. In 2004, you said, you started using the TVT Obturator, correct?
A. I was trained with TVT Obturator in 2004 during my fellowship.
Q. And from, say, 2000 -- 2005 -- rephrase.
When did your fellowship end?
A. 2005.
Q. Beginning in 2005 through 2007, when you said you stopped using the Retropubic, what was the breakdown between TVT-O and TVTTM Retropubic?

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A. I would say that in the beginning, it was more half and half. And then as we got closer to 2007, I had become -- I would say the TVT Obturator was my go-to case.
I didn't use it in all cases, but it was my go-to case --
Q. Did you --
A. -- my go-to sling.
Q. Sorry. I didn't mean to interrupt you.
A. That's okay.
Q. Why did you switch to the TVTTM Obturator from the TVTTM Retropubic?
A. For me, it just was something that I found was easier to do. And I liked -- when you said that everything is a risk/benefit profile the risks of the TVTTM Obturator, to me, of not having as many bladder injuries during the case were -- were more acceptable.
Q. Did you have a lot of bladder injuries with your patients with the TVTTM Retropubic?
A. I had some. They were always recognized and the sequelae were -- were never -- there was really no sequelae from those. But I just

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felt like -- I never liked sending my patients home with a catheter for a day or two. So I pretty much switched to TVTTM Obturator.
Q. The TVTTM Obturator, you don't operate in the retropubic space, correct?
A. Exactly.
Q. And you felt that was a safety advantage, correct?
A. Yes.
Q. So if I understand correctly, beginning in about 2004, 2005, when you were finishing your fellowship up and then going into private practice, you transitioned almost exclusively to the TVTTM Obturator; and then after 2007, in the few cases where you would consider the TVTTM Retropubic, or that approach, you switched to the EXACT®?
A. My first year out was not in private practice. My first year out, I was at Mt. Sinai Hospital, and I was the director of female urology there. And in that year, I was using -- I was using a great deal of TVTTM Retropubics.
Probably, when I transitioned into my private practice, which was 2006, I was starting to become more exclusively a TVTTM Obturator sling --

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Q. So in 2006 --
A. -- user.
Q. I'm sorry.
So in 2006, you transitioned almost entirely to TVTTM Obturator versus a TVTTM Retropubic approach; is that correct?
A. Yes. It was around the time when all the studies were coming out that were showing some equivalency between the TVTTM Obturator and the TVTTM Retropubic sling, in terms of the success data.
Q. In this case, I've read your reports.
It's my understanding that you have certain opinions about the risk/benefit profile of the TVTTM Retropubic, correct?
A. Yes.
Q. Would you agree with me that for you to offer a valid opinion about the risk/benefit profile for the TVTTM Retropubic, you need to be familiar with each of the risks of that device system?
A. Yes, I would agree with that.
Q. It's my understanding that you have some opinions about the warnings for the TVTTM Retropubic; is that correct? Or you don't? If you don't --

A. I'm not sure I understand the question.
Q. Do you have opinions about whether the warnings -- do you have opinions about whether the warnings for the TVTTM Retropubic are adequate or not?
A. Are you talking about the IFU warnings?
Q. Yes.
A. Do I have opinions about whether they're adequate?
Q. Yes.
A. My opinion is that they're adequate.
MR. SLATER: Move to strike.
BY MR. SLATER:
Q. My question is this: Are you intending to offer opinions in this case about the adequacy of the warnings for the TVTTM Retropubic?
A. Absolutely.
Q. Have you ever done that in any litigation before, given warning opinions?
A. In any litigation? No.
Q. When you give your opinions about whether or not the warnings for the TVTTM Retropubic are adequate, are you applying any published

standards for warnings?
A. I don't understand the question.
MS. KABBASH: Objection.
BY MR. SLATER:
Q. Did you consult any published standards for what information is supposed to be provided in a medical device warning like for the TVTTM Retropubic?
A. No.
MS. KABBASH: Objection.
BY MR. SLATER:
Q. Did you review testimony by witnesses from Ethicon who are responsible for making sure the warnings are adequate, to see what standards they applied, in their industry, in determining what should be warned of? Did you look at those standards?
A. I never looked at any testimony from Ethicon, no.
Q. Did you look at any internal documents from Ethicon, where they set out the standards or the criteria that they applied in determining what information needed to be in a warning such as for the TVTTM Retropubic?
A. I don't believe I have, no.

Q. When you offer your opinions as to the adequacy of the warnings, are you essentially advising us what you believe would be adequate for you in your medical practice, with your basic -- with your level of experience and what you're familiar with?
A. Exactly, yes.
Q. There was some reference in your report to the patient brochure or whether or not a patient brochure was shown to Ms. -- Mrs. Corbet, right? You talked about that a little?
A. Yes.
Q. As you sit here now, am I accurate you don't know which patient brochure she actually saw?
A. I can't say exactly. But I know the brochure that was out at the time of her -- of her care.
Q. The patient brochure that was out during the time that she had her surgery in 2011, do you know if that's the patient brochure that she was shown during her deposition?
A. That's the one that she felt was familiar to her, in her deposition.
Q. This is my question -- rephrase.

The patient brochure that was shown to Mrs. Corbet during her deposition, do you know if that's the one that was available during 2011 at the time of her surgery?
A. Yes, it was.
Q. And did you confirm that yourself?
A. Yes.
Q. Did Mrs. Corbet say that is the one she saw or did she say that looks familiar to her?
A. She said that it looked familiar to her.
Q. Have you looked at the patient brochures over the years?
A. Yes, I have.
Q. To somebody who is not used to looking at patient brochures every day, could they look similar?
MS. KABBASH: Objection.
THE WITNESS: I suppose that they could. But I think because that was the patient brochure that was out at the time of her care and that was the brochure that Kathy Hampton had delivered to the offices in that area at that time, it's more than likely that that's the brochure that she had seen.

- - -

(Whereupon, a discussion off the record occurred.)

- - -

MR. SLATER: Move to strike from "but" forward.

BY MR. SLATER:

Q. Dr. Harrell mentioned an InterStim® to Mrs. Corbet before he operated on her.

Is that something you said in your report?

A. That's something he said in his deposition -- I mean, I'm sorry, that was something that was in the medical record.

Q. Did Dr. Harrell recommend an InterStim® to Mrs. Corbet?

A. He warned her that that was a possibility in her future.

MR. SLATER: Move to strike.

BY MR. SLATER:

Q. Did Dr. Harrell recommend an InterStim® to Mrs. Corbet before he operated on her? Did he recommend it to her?

A. Not at the time.

Q. Did Dr. Harrell ever recommend an

InterStim® to Mrs. Corbet and say, I think you should have this put in your body?

A. Yes, he did.

Q. When was that?

A. It was after she had had surgery with him.

Q. Do you have any knowledge as to the agreement between Ethicon and Professor Olmstead and his company? Do you know any of the details of that interaction?

A. I've seen some of the records of that interaction.

Q. Are they listed in your report?

A. Yes -- no, they are listed in my -- yeah, in my exhibit.

Q. Did you discuss that issue at all in your report?

A. No.

Q. Have you been involved in clinical studies?

A. No. I mean, clinical trials? No.

Q. You've never --

A. Clinical studies? Yes. But not clinical trials.

Q. What's your distinction between a

clinical study and a clinical trial?

A. Well, we've written papers based on our -- on our clinical work. You know, I'm a director of fellowship, and so there's many papers that have come out or abstracts that have come out based on our patient population.

Q. And what is a clinical trial?

A. Well, a clinical trial, to me, is something that more involves industry. And I've not been involved in those.

Q. Are you familiar with the concept of financial bias in a clinical trial?

A. Yes.

Q. You would agree with me that financial bias is accepted in the medical field as something that can impact on the results in a study, correct?

A. Except that it's always disclosed.

Q. Financial bias is always supposed to be disclosed, correct?

A. Exactly.

Q. If financial bias is not disclosed in an article written about a clinical trial, that's a bad thing, right?

MS. KABBASH: Objection.

BY MR. SLATER:

Q. Meaning it's not good; you'd rather -- it's supposed to be disclosed, right?

A. It's supposed to be disclosed, but it doesn't necessarily mean it's a bad thing.

Q. Do you think it's a good thing for doctors who perform clinical trials to not disclose their financial bias?

A. We're supposed to disclose our financial bias.

Q. So it's a bad thing not to disclose your financial bias, because people expect you to do so, so when they read the results, they'll have that information in their mind so they can look at the data that you're reporting with that in mind, correct?

A. I would agree, except I don't always think that it affects the results of the data.

MR. SLATER: Move to strike from "except" forward.

BY MR. SLATER:

Q. If the agreement between the person running the clinical trial and the company that is looking to make money on that device that's being studied provides a financial incentive for the

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doctor to report less complications than may be observed, that would be a significant bias issue that everybody should know about when reading those articles written about that study, correct?

MS. KABBASH: Objection.

THE WITNESS: I would have to know more about what you're referring to before I could answer that.

BY MR. SLATER:

Q. Do you know about anything like that happening with Professor Olmstead and his company?

A. I've seen some records, but I can't really take that out of context.

Q. Do you have any opinions, as you sit here now, about whether or not there was any -- rephrase.

Do you feel comfortable that you understand the factual interaction between Ethicon and Professor Olmstead, in terms of what the payments were predicated upon? Do you have an understanding of that?

A. I think I do.

Q. Do you know that there was a provision that said that a certain payment of $400,000 wouldn't be made if complications were

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reported beyond those that had been reported in a prior article?

A. I've seen records of that, but I don't interpret it that way.

Q. You don't interpret it that way?

A. No.

Q. Did you ever ask to see the testimony of the people at Ethicon whose job it is to interpret that type of information?

A. No, because I'm not interested in their testimony. I'm interested in my own interpretation --

Q. Okay.

A. -- of that.

Q. With regard to the agreement between Ethicon and Professor Olmstead and his company, you have no interest in knowing Ethicon's interpretation of that agreement, correct?

A. You're asking me whether I had an interpretation about what that was. And if you'd like to ask my opinion, I'm glad to give it to you.

Q. But I went beyond that. And now we're talking about Ethicon's knowledge about it. And you told me -- so I want to ask it very clean.

You have no interest in understanding

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what Ethicon thinks that agreement between Ethicon and Professor Olmstead and his company means?

A. Right, I don't.

MS. KABBASH: Objection.

THE WITNESS: Because the reason --

BY MR. SLATER:

Q. I didn't ask you why. I don't care. I just want to know you don't care, right?

A. I don't have any --

MS. KABBASH: Objection.

THE WITNESS: I don't care what Ethicon thinks that that agreement was.

BY MR. SLATER:

Q. Would it be fair to say that with regard to the risk/benefit profile of the TVT, you don't care what Ethicon thinks about it, you want to draw these opinions 100 percent based on your own knowledge and experience?

A. No.

MS. KABBASH: Objection.

THE WITNESS: It's not just on my own knowledge and experience. It's on the experience of the vast medical literature that's out there. That has nothing to do with Ethicon.

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BY MR. SLATER:

Q. Well, this is the question: In drawing your opinions regarding the risk/benefit profile for the PROLIFT® -- I called it the PROLIFT®.

MS. KABBASH: You're in PROLIFT® mode.

BY MR. SLATER:

Q. In drawing your opinions with regard to the risks and benefits of the TVTTM Retropubic, you did not base that upon what Ethicon has said, what Ethicon witnesses have said, or Ethicon internal documents?

A. Right.

Q. Is that fair?

A. That's fair.

Q. Okay. Your opinions about the risks and benefits of the TVTTM Retropubic are based on your personal experience and your review of the literature, correct?

A. Exactly. My training.

Q. If Ethicon internally -- well, rephrase.

Do you think that Ethicon has access to more information about the potential

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complications with the TVTTM Retropubic than you would have, since they sell the product and interact with doctors around the world about it?
A. No, I don't think that Ethicon internally has that information.
Q. Okay. If there are risks or adverse reactions relating to the TVTTM Retropubic that you're not familiar with but that Ethicon agrees exist, that could have an impact on your overall opinion if you were to be shown severe risks, for example, you didn't know about, right?
MS. KABBASH: Objection.
THE WITNESS: I have a hard time believing that there are severe risks that I don't know about, since I've done 1,500 or more of these slings --
BY MR. SLATER:
Q. Well, you haven't done --
A. -- in my career.
Q. -- 1,500 or more TVTTM Retropubics, have you?
A. I haven't 1,500, but I've probably done about 400. I think that that's enough to know the risks of the procedure.
Q. Your patients don't always return to

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you when they've had complications, do they?
A. I would say that they probably do.
Q. You think every single patient you've ever had that had a complication came back to you for treatment of that complication?
A. Not every single, but the majority of patients, yes.
Q. You have no idea how many of your patients have had complications and left you and not come back? You don't know, right?
A. I'm sure there are some that haven't. But I think the majority of my patients, I'm aware when they have a complication.
MR. SLATER: Move to strike from "but" forward.
BY MR. SLATER:
Q. You have no way of knowing how many of your patients have had complications from your insertion of a TVT device and not returned to you for that treatment? You just have no way of knowing that, correct?
MS. KABBASH: Objection.
THE WITNESS: I think I do know when people have complications from my slings that I've put in.

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BY MR. SLATER:
Q. So we're going back-and-forth in a tennis game.
Now it's you know everybody? You know every complication you've had with a patient?
MS. KABBASH: Objection.
THE WITNESS: I'm not saying I know every complication.
MS. KABBASH: Mischaracterizes.
THE WITNESS: I'm saying I know the majority of the people who have had complications, because they come back.
BY MR. SLATER:
Q. Have you ever -- do you have a registry for all your patients that you've ever put a TVT into?
A. No. I have an electronic health record. I don't -- I don't keep registries on my patients.
Q. An electronic health record, that's not what I was asking, was it?
A. No.
Q. It has nothing to do with a registry, right?
A. Right. I don't have a registry.

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Q. This is a very simple question. You have no way of knowing how many of your patients have had mesh-related complications from a TVTTM Retropubic and not returned to you for care? You don't know that, right?
A. I can't give you an exact number.
Q. You couldn't give me an estimate, because you don't know, right?
MS. KABBASH: Objection.
THE WITNESS: I would say that I can give an estimate, because most of my patients return to me in follow-up. And when they're having a problem, they will tell me.
BY MR. SLATER:
Q. Have you ever done a study of your patient population to determine how many didn't tell you when they began to have mesh-related complications from a TVTTM Retropubic and went for care elsewhere? Have you ever studied that question?
A. No. However, I work in a very small community, and we do see our patients back. And if we don't, we're usually told where they've gone.
MR. SLATER: Move to strike from "however" forward.

BY MR. SLATER:
Q. Are you aware that in the medical literature, it's been recognized that patients who have mesh-related complications will often go to other doctors without informing the implanter and the implanter won't know about it?
A. My review of the medical literature shows the majority of patients do go back to their implanting doctor.
Q. Which study is that?
A. In the Welk study it showed that --
Q. Welk, W-E-L-K?
A. Uh-huh. Yes.
Q. Right. Said what?
A. That --
MS. KABBASH: What was the question?
MR. SLATER: She knows what the question is.
BY MR. SLATER:
Q. Go ahead.
MS. KABBASH: Do you?
THE WITNESS: That the majority of patients went back to their original doctor.
BY MR. SLATER:
Q. In the Welk study?

A. Yes.
Q. What time period were patients being studied for in that study?
A. I can look at it, and I'll tell you exactly.
Q. It doesn't matter, if you don't remember. I just want to see.
How many patients were studied?
A. About 60,000 patients.
Q. What were they looking at?
A. They were looking at complications from sling procedures.
Q. Where were they collecting these 60,000 patients from?
A. From the registry, Canadian registry.
Q. Okay. That's Canada, right?
A. Yes.
Q. Is Canada a different health system than we have in the U.S.?
A. As far as I know, yes.
Q. It's a socialized system, right?
A. Yes.
Q. A lot less doctors, right?
A. Yeah, that's true.
Q. A lot less options for treatment in

Canada than the U.S., right?
A. Yes.
Q. Are you familiar with any articles in the peer-reviewed literature that do state that patients will often not return to the implanting physician when they have mesh-related complications and the implanter will not know about it? Have you use seen that discussed in the literature?
A. I have seen a place that it was discussed in the literature, yes.
Q. Where was that?
A. In the Abbott article.
Q. That's the only article you're familiar with that talks about that?
A. That's the one that comes to mind right now.
Q. How many of your patients -- rephrase.
Let's try to get some numbers.
A. Sure.
Q. How many -- you tell me, would it make sense to talk about your fellowship, too, when you're placing -- if we want to get your statistics, I guess it would, right?
A. If you'd like.

Q. Let's do this. Let's talk about the fellowship first.
A. Okay.
Q. In your fellowship, how many mid-urethral synthetic slings would you estimate you placed?
A. I probably did between three and five per week. And that was over a year. We didn't just do mid-urethral slings that year, I mean, we were doing other slings, too, pubovaginal --
Q. I didn't ask you about other slings.
A. I'm -- you're asking me to calculate. Let me calculate, counselor.
I would say about 150.
Q. Of the 150 mid-urethral slings that you estimate you placed during -- this is one year in your fellowship?
A. In my fellowship, yes.
Q. -- how many would you say were TVTTM Retropubic?
A. The majority. I can't give you an exact number.
Q. I'm not asking for an exact number.
When you say "majority" are we talking --

A. 80 percent.
Q. Okay. Fine. And the other 20 percent would be what mid-urethral slings?
A. TVTTM Obturator slings were the only other synthetic slings we were doing at the time.
Q. Of the patients that you placed TVTTM Retropubic during your fellowship -- first of all, how long did you personally follow those patients?
A. In fellowship? Not long. I was only there for a year.
Q. Do you know anything about their complications or course after you left the fellowship?
A. No.
Q. After your fellowship, how many -- rephrase.
After your fellowship, right up until now, how many mid-urethral slings would you say you've placed, synthetic mid-urethral slings?
A. Probably a couple hundred.
MS. KABBASH: You mean retropubic specifically or all mid-urethral slings?
MR. SLATER: I'm talking all mid-urethral slings.
THE WITNESS: Oh.

MS. KABBASH: All mid-urethral slings.
THE WITNESS: I'm so sorry. I misunderstood the question.
MR. SLATER: I'll ask it again.
THE WITNESS: Yes, please.
BY MR. SLATER:
Q. Since your fellowship, which you completed in 2005, right?
A. Yes.
Q. How many synthetic mid-urethral slings would you estimate you've placed from 2005 until now when we're in late 2015?
A. Over 1,500.
Q. Of the over 1,500 mid-urethral slings that you've placed since 2005, can you estimate how many are TVTTM Retropubic?
A. A couple of hundred.
Q. "A couple hundred" means about 200?
A. About 200.
Q. The balance would be?
A. Towards the beginning of that time period.
MS. KABBASH: Do you need some water?
THE WITNESS: No, it's okay. I'm

fine.
BY MR. SLATER:
Q. The approximate 200 TVTTM Retropubics would have been placed between 2005 and 2007?
A. Exactly.
Q. The balance of the mid-urethral slings you've placed would be primarily TVTTM Obturator, correct?
A. Yes, after that, it was mostly TVTTM Obturator --
Q. And maybe --
A. -- with some sporadic TVTTM Retropubic or EXACT® in there.
Q. When you say "sporadic," you're talking about maybe a few a year?
A. Exactly. Except in the last year, I've been doing more EXACTs than in the previous years.
Q. Have you used mid-urethral slings manufactured by someone other than Ethicon?
A. I have. But it was for a very short period of time.
Q. Which device?
A. It was a device by a company called GMD, General Medical Devices. I don't think they

exist anymore. I'm not sure. And I was probably --
Q. Lucky them.
A. -- using their sling for about a, you know, a month or two. I was trialing it.
Q. Did you ever try the AMS slings, the Arc slings, any of that?
A. I've never tried any of those slings.
Q. How come?
A. Because I liked the results I was getting with TVT and Obturator -- Retropubic and Obturator. I'm afraid to switch.
Q. Now, speaking about your fellowship, the TVTTM Retropubics that you placed, those patients you saw for no more than a year, most of them it would be less than a year as you went forward toward the end, right?
A. Right. Following them for a year.
Q. So you don't know their outcomes?
A. Not their long-term outcomes.
Q. Well, "long-term" is how long?
A. More than a year in this case.
Q. Well, when you define long-term in evaluating the medical literature, is that more than one year?
A. Well, I would probably say it's more

about five years is long-term literature.
Q. For the TVTTM Retropubics you placed between 2005 and 2007, how many of those patients returned to you with mesh erosions or mesh exposures?
A. In that time period, I probably had more mesh exposures than I have now.
Q. I --
A. But I can't give you an exact number. It was something that I saw probably about 5 to 10 percent of the time. When I was first doing slings, I definitely had more mesh exposures.
Q. And that was with the TVTTM Retropubic?
A. Or TVTTM Obturator.
Q. So if I understand, during the period of 2005 to 2007, when you were performing TVT Retropubic, you estimate, based on your recollection, that you had about a 5 to 10 percent mesh exposure/erosion rate, correct?
A. In -- yes, in those years, I did. And then later on, it became extremely rare.
MR. SLATER: Move to strike from "and" forward.
BY MR. SLATER:

Q. With regard to the two -- well, withdrawn.
- - -
(Whereupon, a discussion off the record occurred.)
- - -
BY MR. SLATER:
Q. With regard to Mrs. Corbet, there were -- well, let me take a step back, actually. I did forget to ask you about something.
When you treat stress urinary incontinence, you don't only use mid-urethral slings, correct?
A. That's correct.
Q. Currently, and over the years, you've used various procedures to treat that condition, right?
A. I have.
Q. In addition to mid-urethral slings, what are the other procedures that you have utilized in your practice to treat stress urinary incontinence?
A. I've used autologous fascial slings. I've used bulking agents. And I also do robotic Burches.

Q. When did you transition to robotic Burches from laparoscopic?
A. I never did laparoscopic.
Q. You never did. You meant from went from open to robotic?
A. I never did open.
Q. When were you trained on robotic Burch procedures?
A. I was never formally trained on robotic Burch procedures. I was trained on open Burch procedures during my fellowship. And when I started doing robotic sacrocolpopexy, I began doing some robotics Burches at that time.
Q. Do you perform Burch procedures where you're not doing them in conjunction with an abdominal sacrocolpopexy for prolapse?
A. Never.
Q. With Mrs. Corbet, for example, with her condition, would one of her options have been abdominal sacrocolpopexy with a Burch?
A. It would have been an option. Patients always have options.
Q. Ultimately, the choice for what procedure would be performed on Mrs. Corbet was Mrs. Corbet's decision, correct?

A. Her decision that she made with Dr. Harrell, yes. But it was her decision.
Q. The patient, Mrs. Corbet, in this case, has the ultimate say-so on whether or not, for example, a mesh device is put in her body, correct?
A. Yes. But she's counseled by her doctor. Patients don't understand mesh --
MR. SLATER: Move to strike.
THE WITNESS: -- until their doctor counsel's them.
MR. SLATER: Move to strike from "but" forward.
BY MR. SLATER:
Q. I would contend that many doctors don't understand mesh. So I don't know why you keep throwing in the thing about the doctors.
I didn't ask you about that, did I?
A. I guess you didn't.
Q. Okay. I'll try it again.
Ultimately, for Mrs. Corbet, the decision as to whether or not she would place mesh in her body was her decision, correct?
A. It's always the patient's decision, yes, ultimately.
Q. Mrs. Corbet would hear the

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recommendations, and heard the recommendations and information she got from Dr. Harrell, and then made a decision based on what he told her, correct?
A. Yes. And also, but she might have seen a patient brochure and some other things out in the community, some people talk to their friends, they talk to their siblings, their family. It's not just from the doctor that they get information from.
MR. SLATER: Move to strike after "yes."
BY MR. SLATER:
Q. Is there any evidence you've seen that Mrs. Corbet was talking to friends and family and people on the street about what surgery to have?
A. Not Mrs. Corbet specifically. But you asked me where do patients get information from, and I'm telling you.
Q. I asked about Mrs. Corbet. So I'm asking about Mrs. Corbet.
Did you see any evidence in the record, any reference to her speaking to people beyond Dr. Harrell to get information that she would rely on?
A. Only from the patient brochure that she might rely on.

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Q. Mrs. Corbet testified that she glanced at a brochure around the time of the surgery, correct?
A. Yes.
Q. She didn't say she read through it carefully, did she?
A. I can't speak to how -- how much she read it. I know that it was available to her and that she could understand information from there if she chose to.
Q. There's no record indicating that she actually read the patient brochure cover to cover? That's not established, is it?
A. It's established that she found that brochure familiar only.
Q. Other -- rephrase.
You told me that in addition to mid-urethral slings, you utilize, autologous fascial slings, bulking agents and robotic Burch to treat stress incontinence.
Anything else?
A. Not that I can think.
Q. In your current practice, do you use autologous fascial slings, bulking agents, and robotic Burch procedures to treat stress

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incontinence?
A. Yes.
Q. From your perspective, they're all acceptable options to treat stress incontinence, correct?
A. Acceptable, but not first-line, usually. But options, yes.
Q. They're -- rephrase.
I think I saw something in your report about gold standards and standards of care and all that kind of stuff I tend to see in these expert reports.
So I want to talk to you about that for a minute.
A. Sure.
Q. First of all, the gold standard is not a medical term, right?
A. No, not a medical term.
Q. Do you know what the gold standard actually was back in history?
A. It had to do with gold.
Q. Right. Where gold was the valuation basis for our entire financial economy.
A. Financial economy, yes.
Q. The gold standard no longer exists in

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this country, does it?
A. I don't think so, no, not in terms of that.
MS. KABBASH: Objection.
BY MR. SLATER:
Q. Have there been gold standard medical procedures that are no longer performed?
A. Yes.
Q. Asbestos --
A. I'll give you an example.
Q. Sure.
A. The Burch colposuspension used to be the gold standard procedure for stress urinary incontinence that we compared all stress incontinence procedures to. Now it's no longer that.
Q. Well, I didn't ask you that.
MR. SLATER: So move to strike.
BY MR. SLATER:
Q. I asked you if there were gold standard medical procedures that are no longer performed?
A. I'm sure. Because technology is always changing and improving, and we find better ways of treating things. Sometimes we're minimally

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invasive, less complications and those become the gold standard.
Q. Okay. Sometimes there are medical procedures that are touted as a gold standard and it turns out that the complications that they're causing are much higher than what people thought or more severe than people thought, and that changes people's perception over time.
That's happened, correct?
A. Yes. That's why we have medical literature out there. Level 1 evidence that tells us what the gold standard is at the time.
Q. Are you familiar with things in our economy, our commercial economy, that have been called gold standards for things -- like asbestos was a gold standard for insulation?
A. This is not my area.
Q. You wouldn't want asbestos in your house, would you?
A. No. I would probably have it removed.
MS. KABBASH: Objection.
THE WITNESS: But this is not my area, and I can't really speak about this kind of thing.

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BY MR. SLATER:
Q. Do you know where the term gold standard came from in the medical community? Do you know how the genesis of that was?
A. I think you're going to tell me.
Q. I'm asking you. Do you know?
A. No, I don't.
Q. Do you know whether there were doctors being paid by industry who helped to start that rumor that it was the gold standard?
MS. KABBASH: Objection.
THE WITNESS: I'm not aware of that, no.
BY MR. SLATER:
Q. Okay. The mid-urethral sling is not the standard of care treatment for stress incontinence; it is a permissible treatment within the standard of care, correct?
MS. KABBASH: Objection.
THE WITNESS: I think there's multiple, multiple articles and literature out there now that support it as the gold standard.
BY MR. SLATER:
Q. I didn't ask you about the gold standard. Stick with me.

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A. I'll try.
Q. You understand -- I think you used the term standard of care in your report, right?
A. Okay.
Q. Is this your first deposition?
A. Yes.
Q. Okay. Have you ever been an expert in any other case before?
A. Yes.
Q. What type of case?
A. A malpractice case.
Q. Were you plaintiff or defense expert?
A. Defense.
Q. One case?
A. Two.
Q. Those were in New York?
A. Uh-huh.
Q. Where you don't get deposed?
A. Right.
Q. You actually didn't write a report?
A. We don't have to write reports.
Q. You make disclosures and show up and they hand in the C.V., and everyone tries to figure out who you are real quick?
A. Right.

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Q. Did you testify in court?
A. Yes.
Q. Twice?
A. Yes.
Q. How did you do?
A. We won.
Q. So you understand -- rephrase.
So you understand what standard of care means, right?
A. Yes, I do.
Q. The mid-urethral sling is an acceptable treatment within the standard of care for the treatment of stress urinary incontinence, correct?
A. Yes, it is.
Q. There are other acceptable treatments for stress incontinence that are within the standard of care as well?
A. Of course.
Q. Autologous fascial slings is one, correct?
A. Absolutely.
Q. Bulking agents is one, correct?
A. Yes.
Q. A Burch procedure is one, correct?

A. Yes.
Q. Behavior modification is one?
A. Yes.
Q. For some women, that can be very helpful, right?
A. It can.
Q. There is nobody and certain -- rephrase.
You certainly would not be giving the opinion that the only treatment acceptable within the standard of care for stress incontinence is the mid-urethral sling; that's not your opinion, is it?
A. It's not. I told you I do other slings, and I do other -- other procedures for stress incontinence.
Q. Autologous fascial sling would have been an acceptable treatment for Mrs. Corbet, correct?
A. Possibly. I don't know if Dr. Harrell does autologous fascial slings.
Q. Was Mrs. Corbet limited to only Dr. Harrell, or could she have gone to somebody else to have her treatment?
A. That would have been her prerogative.
Q. So if Dr. Harrell had -- rephrase.

If Dr. Harrell had told Mrs. Corbet information and she had any concerns about the TVTTM Retropubic, based on what she heard, she could have asked him about other options, and if he said I don't do those, she could have gone and seen a different doctor and gone a different way, right?
A. I suppose she could have.
Q. That happens in medicine, right?
A. It does.
Q. Burch would have been an acceptable treatment for the stress urinary incontinence of Mrs. Corbet, correct?
A. It would have been acceptable; much more invasive, but it would have been acceptable.
MR. SLATER: Move to strike after "much more invasive."
BY MR. SLATER:
Q. Would robotic Burch that you perform have been an acceptable treatment for Mrs. Corbet's stress incontinence?
A. I would never have done a robotic Burch on Mrs. Corbet unless she was getting a sacrocolpopexy at the same time.
Q. That's your practice, correct?
A. That's the practice. And that's also

in the guidelines, the ACOG guidelines.
Q. So an open Burch would have been acceptable, not a robotic Burch?
MS. KABBASH: Objection.
BY MR. SLATER:
Q. Let me rephrase.
An open Burch procedure would have been an acceptable treatment for Mrs. Corbet's stress incontinence, correct?
A. Yes. Much more invasive, but acceptable.
MR. SLATER: Move to strike after "yes."
BY MR. SLATER:
Q. In the medical community today, there are doctors performing open Burch procedures, correct?
A. I'm sure, yes. Not many, though. I don't know any, actually.
MR. SLATER: I move to strike from "not many" forward.
BY MR. SLATER:
Q. Have you done a study, a scientific study or analysis, to determine how many physicians are performing open Burch procedures currently?

A. No. But I just don't -- I mean, speaking to my colleagues, I can't tell you the last time I heard somebody say they did an open Burch on somebody. It's just not really done so much anymore.
MR. SLATER: Move to strike from "but" forward.
BY MR. SLATER:
Q. Before Mrs. Corbet's surgery, was she taking any medication for her urge incontinence that you have opined she had?
A. No, she wasn't. Not that anyone prescribed for her that I saw.
Q. You saw no reference in any record that Mrs. Corbet had been recommended medication to treat urge incontinence before her 2011 surgery, correct?
A. No, I didn't see that in the record.
Q. After the procedure that Dr. Harrell performed, ultimately, medications were prescribed and Mrs. Corbet was taking medication to try to treat her urge incontinence, correct?
A. Yes. But that doesn't mean that she couldn't have been prescribed medications before her surgery. That was just not what the doctor chose to

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do. She had urgency before her surgery.
MR. SLATER: Move to strike from "but" forward.
BY MR. SLATER:
Q. After the TVTTM Retropubic procedure, Mrs. Corbet began to take medication for urge incontinence, correct?
A. Yes.
Q. Despite that, her urge incontinence persisted and actually worsened, correct?
A. No, that's not true. She did get -- she did get better with medications.
Q. Let me ask it this way: Mrs. Corbet seemed to have some improvement from the medication in the short-term, correct?
A. Yes, she did have some improvement.
Q. Over the long term, that was not sustained, right?
A. But that's often the way it is with urgency.
Q. Despite being on medication, Mrs. Corbet continued to have urge incontinence, it just seemed to be somewhat improved for a period of time, correct?
A. Yes.

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Q. After Mrs. Corbet's surgery, her incision healed well, correct? Let me -- let me be specific.
After the procedure performed by Dr. Harrell, he noted in the records, over time, that her incision healed well, correct?
A. Yes.
Q. She seemed to heal well in general, correct?
A. I'm trying to figure out --
MS. KABBASH: Objection.
THE WITNESS: -- how to answer that.
BY MR. SLATER:
Q. I'm talking about the incisions.
The incisions appeared to heal well, correct?
A. Yes. There's one part in the record where he talks about a little area that's granulating. But other than that, he doesn't make any comment about the incisions not healing well.
Q. Let me ask you this: The granulation tissue that Dr. Harrell noted, he never provided a specific location for that, did he?
A. No, he did not.
Q. So you're not drawing an assumption

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as to where it was? You don't have information to say exactly where it was?
A. But you didn't ask me that. You just asked said, are the incisions healing well. So I'm saying there was a granulating area.
Q. I understand. I'm asking about the granulation tissue, because I know there was a reference to it.
A. Right.
Q. We don't have information as to where with it specifically was, correct?
A. Exactly. Right.
Q. It could have been adjacent to the incision? It could have been away from the incision, correct?
A. Exactly. Well, there were several incisions, so I'm not sure which incision you're talking about.
Q. The TVT incision.
A. Okay.
Q. You said something in your report about -- actually, I'll withdraw that. I don't that need that for today.
The granulation tissue that Dr. Harrell observed, that was possibly due to the TVT

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mesh, possibly not; you don't know, correct?
A. Right.
Q. I saw a note in February of 2012, and you referred to it in your report, where on February 19th, 2012, De. Herrell's exam showed a normal vaginal mucosa.
Do you recall that?
A. I don't recall it. I can look at it if I --
Q. If you want to look at your report, you can.
Why don't we do this, why don't we -- you know, I'm going to hold off on that. We'll come back to that. Let me mark some more documents and identify some documents, and we'll come back to talking about the case.
- - -
(Whereupon, Exhibit Fleischmann-2, 6/26/14 Letter and Invoices, was marked for identification.)
- - -
BY MR. SLATER:
Q. Exhibit-2 in front of you is a June 26th, 2014, letter and, it looks like, some invoices.

What is -- what is this exhibit?
A. These are my invoices regarding my services.
Q. What's the total you've been paid in this case up until now?
A. You know, I have that in my notes, because I added it up. So let me just --
MS. KABBASH: You can reference them.
THE WITNESS: Thank you.
MS. KABBASH: You're speaking about Corbet, Adam?
MR. SLATER: Corbet.
THE WITNESS: Corbet? It's hard to say exactly Corbet.
BY MR. SLATER:
Q. Well, Corbet and the general reports, since you're putting your general report into the Corbet case?
A. Right.
Q. So it's the work you've done related to the reports and opinions that you're going to offer in the Corbet case?
A. It's about $58,000.
Q. Just so you know, I'm looking at these invoices now.

There's June 26th, you were paid $25,000, right?
A. Right.
Q. And then there's --
MS. KABBASH: There's some time for Cantrell in here, Adam.
THE WITNESS: Right. That's why -- that's why it gets a little bit dicey, because some of this is for a different case.
BY MR. SLATER:
Q. If we wanted to, we could break out the hours that mention Cantrell, and then we could subtract those out, right? As best we could, I suppose?
A. We could. But I think we did the calculation, tried to do it, anyway, before I got here.
Q. So your calculation is you billed about $58,000 --
A. Specifically for Mrs. Corbet and the general report, not including Mrs. Cantrell.
Q. How -- where does that take us up to?
A. That takes us up to our -- prior to the supplemental report and the dep prep, the deposition prep.

Q. How much time did you spend on -- did you spend on the supplemental report, prepping for the deposition, up until today?
A. It's been about 100 hours, give or take.
Q. And your rate is what?
A. $500 an hour.
Q. So another $25,000. Is that good math?
A. No, that's not good math.
Q. Let me ask you this: What is 100 hours times $500 an hour? Is that --
A. Just divide it by 2, and you'll get the number.
Q. I'm so bad at math.
A. Really?
Q. Is it $50,000?
A. I think so. 100,000 divided by two.
Q. 100 hours times $500 is that $50,000?
A. That would be more -- better math.
Q. So you're estimating between your prior invoices and what you've -- the time you spent up before today, about $108,000?
A. Probably about that, yes. That's to be billed, though.

Q. Got it. You do plan to bill for that, though, right?
A. I plan to, yes.
Q. I see you got to talk to Burt Snell?
A. Only on the phone. Once, maybe. Did I ever?
Q. Tell him, hello. Tell him hello the next time you spoke to him. I haven't seen Burt in a while.
What is -- what are the rates that you're going to charge for trial?
A. For a full day it's $7,500.
Q. And for a half day?
A. It's $4,000.
- - -
(Whereupon, Exhibit Fleischmann-3, Progress Notes, was marked for identification.)
- - -
BY MR. SLATER:
Q. Exhibit-3 is a set of progress notes. Are those your handwritten notes from your exam of Mrs. Corbet?
A. Yes. I'm just looking at yours. I have to find mine, right? Here they are.
Q. When did you write those notes?

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A. This was done in realtime.
Q. While she was present in the room?
A. While she was present on the date. And I can give you the date, if you let me look at my -- my record. Because I don't see that this is dated. My supplemental -- I need -- it would be my supplemental report.
That would be October 9th, 2015.
Q. When you examined Mrs. Corbet, she told you that she had pain with intercourse, correct?
A. Yes. Yeah, she told me that before the exam, but --
Q. Let me rephrase.
When you met Mrs. Corbet, you took a history and asked her questions, correct?
A. Yes.
Q. She told you she had pain with intercourse, correct?
A. Yes.
Q. When you examined Mrs. Corbet, you found that she had tenderness in the area where the mesh erosion had been excised and removed, correct?
A. It's hard for me to say exactly, but it's in the area of the trajectory of a mid-urethral

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sling.
Q. And I think you said that the scar from -- on the vagina actually tracked away from the incision in that -- into the left, where the mesh excision had taken place, correct?
A. I think so, yes.
Q. So it's reasonably likely that that extended scar correlates to the removal of mesh by Dr. Smith, correct?
A. Well, it correlates to the surgery that had been done in that area, yes.
Q. And that's the location -- one of the locations -- rephrase.
And Mrs. Corbet reported tenderness when you palpated that area?
A. Yes.
Q. That made medical sense that she would complain of tenderness at that location? It wasn't something that you would say, why would someone complain of tenderness there, right?
MS. KABBASH: Objection.
THE WITNESS: I don't understand that question.
BY MR. SLATER:
Q. When you palpated and felt tenderness

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at the location where the erosion had been and where there was scarring now from that surgery to remove the eroded mesh, in medicine, tenderness such as was elicited can result from that type of a condition and surgery, correct?
A. Well, she had -- she had scarring at that area where she had had surgery. And that's where she was feeling pain.
Q. Surgery to remove the mesh, correct?
A. I'm assuming. I mean, I can't really say what exactly happened at that spot. I can just tell you that she had scarring at that area and that was the area that she was feeling tenderness.
Q. In drawing your opinions, you're assuming that scarring was from the removal of the mesh, correct?
A. I would assume, but I can't -- I can't say for sure.
Q. But that's your assumption?
A. Yes.
Q. You would agree with me that based on your exam and that finding, that the dyspareunia that Mrs. Corbet is complaining of is at least, in part, being caused by the tenderness she feels at the location where the mesh had been removed,

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correct?
A. She's feeling pain at the site where she had a surgical procedure, yes.
Q. A surgical procedure to remove eroded mesh, correct?
A. She had multiple surgical procedures. First, she had a procedure to place it. She might have even had surgery back in the early '80s to -- in that area.
It's really hard to know exactly what happened in that area. But I can just tell you that in that area is where she had pain and there was scar tissue.
Q. You believe that the area where she had scar tissue where she was complaining of pain, which correlates to where the eroded mesh was removed, that is contributing to her sensation of dyspareunia, correct?
A. In the area that she had surgery, whether it was to place the sling, remove the sling, or whatever had been done back in the early '80s, that is where she had pain because she had scar tissue, yes.
Q. Whatever surgery she had in the early '80s, Mrs. Corbet was not complaining of any

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dyspareunia or discomfort with intercourse, whatsoever, when she went to Dr. Harrell, correct?
A. Right.
Q. So whatever had happened before Dr. Harrell operated, it was not causing her any pain or discomfort with sexual intercourse whatsoever, correct?
A. She didn't complain of that.
MS. KABBASH: Objection.
BY MR. SLATER:
Q. Do you have any reason to think she had such pain or discomfort?
A. No. But she also didn't have a lot of complaints of pain in the record following that either. So it's hard to know.
MR. SLATER: Move to strike --
THE WITNESS: The record doesn't reflect her dyspareunia after that either.
MR. SLATER: Move to strike from "but" forward.
BY MR. SLATER:
Q. You're not offering an opinion that Mrs. Corbet had either dyspareunia or discomfort with sexual intercourse before Dr. Harrell's surgery, are you?

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A. No, because she doesn't complain about that in her deposition. But if we're talking about the medical record, she doesn't complain about pain in the medical record either.
MR. SLATER: Move to strike after "no."
BY MR. SLATER:
Q. Let's make one thing clear. After the surgery, she does complain of dyspareunia, and she even complains of it to Dr. Scott in 2014 and 2015, correct?
A. Yes.
Q. She complained of dyspareunia to you, correct?
A. Yes, she did.
Q. She complained of dyspareunia to Dr. Rosenzweig, right?
A. Yes. But not to Dr. Smith who was her treating physician.
MR. SLATER: Move to strike from "but" forward.
BY MR. SLATER:
Q. The fact that, according to your reading of the deposition and the records, Mrs. Corbet stopped complaining of dyspareunia to Dr.

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Smith doesn't mean she wasn't having it, correct?
A. I can't speak about that. I just know that Dr. Smith was her treating physician and she never complained about it to her, who would have been the primary person she should have talked to about this.
Q. It doesn't mean she didn't have discomfort with sexual intercourse; there may be a reason she that didn't tell Dr. Smith, right?
MS. KABBASH: Objection.
THE WITNESS: I really can't comment on that.
BY MR. SLATER:
Q. Was Mrs. Corbet asked that by the defense lawyer that questioned her? Why didn't you tell Dr. Smith you were still having discomfort with sexual intercourse?
A. I don't recall.
Q. Did you do a full vaginal examination?
A. Yes.
Q. Did you find that -- rephrase.
I saw no references to her vaginal length or vaginal architecture being misshapen in any way; it's not as large as it should be.

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You made no findings of a shortened vagina or --
A. No.
Q. -- or any other vagina -- let me ask it again, because I went rambling.
A. Okay.
Q. When you examined Mrs. Corbet, you made no findings of a shortened vagina, correct?
A. Right.
Q. You found -- made no findings of a narrow vagina, correct?
A. No. But she did have scarring in her vagina.
MR. SLATER: Move to strike.
BY MR. SLATER:
Q. When you examined Mrs. Corbet, you did not -- you did not find any narrowing of the vagina, correct?
A. No, not narrowing, but she had scarring.
Q. Why are you throwing in the scarring?
A. Because you could feel -- feel a band of scarring over her posterior vaginal wall, so that's why I'm throwing that in, because I felt it.
Q. The location of the scarring you felt

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on the posterior vaginal wall, is that further back in the vagina from the scarring in the location where the eroded mesh was removed?
A. It's a completely different place from her previous -- from her anterior surgery.
Q. What I'm asking is, if one were to be going from front to back, you would get to the scar tissue from the -- where the erosion was first before you get to the posterior scarring, correct?
A. I don't understand the question at all.
From front to back? How are you -- we don't think of those terms.
Q. From the vaginal opening going internal?
A. From the introitus to the cervix --
Q. Yes.
A. -- or the top of the vagina. You're asking --
Q. Which one is closer to the introitus?
A. They're just about equally close.
Q. The posterior, it would be on the bottom, the anterior --
A. Exactly.
Q. -- scarring would be on the top?

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A. Exactly.
Q. You found levator muscle spasm when you examined Mrs. Corbet, correct?
A. She was definitely tender over the levators. The good thing is that she could relax and contract them, which people who have severe levator spasm can't do. So she was able to relax her levators properly.
Q. Well, let me ask it then.
You found tenderness bilaterally on both levators?
A. Yes, and in the midline as well. Her entire posterior vaginal wall was very tender, all the way to the levators.
Q. Did you find actual hardening or spasm or just tenderness?
A. Tenderness, but less spasm because she was able to relax and contract her muscles properly. Most people with levator spasm can't do that.
Q. I didn't see any reference in your report to finding any spasm or hardening of the --
A. Right.
Q. -- levators.
There was none?

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A. No, not that I found.
Q. And that was before she actually was asked to try relax the muscles? That was -- after you exam, then you say can you relax them, and she was able to do that?
A. Can I look at my --
Q. Sure.
A. -- report, because I don't recall exactly what I wrote there.
So there was scarring noted on the anterior and posterior wall of the vagina --
Q. Doctor, just so you know, you can read quietly to yourself. I just want to know the answer to my question about whether or not --
A. So I wrote, She had specific tenderness of the levator muscles on both sides equally and she was able to relax and contract these muscles upon command.
Q. So you found spasm or hardness, correct?
A. Right.
Q. You found only tenderness?
A. Only tenderness.
Q. And then after you found that, she was able to relax the muscles at your request?

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A. Exactly.
MS. KABBASH: Adam, can we plan a break around 11:00? It's 15 minutes from now.
MR. SLATER: Whenever you want.
- - -
(Whereupon, a discussion off the record occurred.)
- - -
MS. KABBASH: Why don't we do it now, if that's all right?
MR. SLATER: Sounds like a good time.
VIDEO TECHNICIAN: The time is 10:46 a.m. We are going off the record.
- - -
(Whereupon, a brief recess was taken.)
- - -
(Whereupon, Exhibit Fleischmann-4, Expert Report on TVTTM Retropubic, N. Fleischmann, M.D., was marked for identification.)
- - -
VIDEO TECHNICIAN: This marks the beginning of Videotape Number 2. The time is 10:55 a.m. Back on the record.
BY MR. SLATER:

Q. Doctor, I've marked a few exhibits I just want to, for the record, establish what they are.

What is Exhibit-4?

A. Exhibit-4 is my expert general report on TVTTM Retropubic.

- - -

(Whereupon, Exhibit Fleischmann-5, Expert Report on K. Corbet, N. Fleischmann, M.D., was marked for identification.)

- - -

BY MR. SLATER:

Q. What is Exhibit-5?

A. That is my expert report on Kathryn Corbet, the case of Kathryn Corbet.

- - -

(Whereupon, Exhibit Fleischmann-6, Supplemental Expert Report on K. Corbet, N. Fleischmann, M.D., was marked for identification.)

- - -

BY MR. SLATER:

Q. What is Exhibit-6?

A. That is the supplemental report that I wrote on the case of Kathryn Corbet.

- - -

(Whereupon, Exhibit Fleischmann-7, Materials Reliance List, was marked for identification.)

- - -

BY MR. SLATER:

Q. What is Exhibit-7?

A. The list of materials I've relied upon for my opinions.

Q. Now, you have lists of things you have relied in your -- attached to Exhibit-4, to your general report, right?

A. Yes.

Q. So what is -- Exhibit-7, what is that, more materials or is it the same thing? It looks like it's --

MS. KABBASH: It's an update, Adam.

MR. SLATER: It's an updated list of things relied on?

MS. KABBASH: Yes.

BY MR. SLATER:

Q. Let me understand something. When you wrote your general report, Exhibit-4, I think you dated it, actually.

Your general report in this case is July 8, 2014, correct?

A. Where do you see the date?

Q. Page 30.

MS. KABBASH: It's on Page 30.

THE WITNESS: Oh, sorry.

The date I signed it, probably, yes.

BY MR. SLATER:

Q. This report contains each of the opinions that you had formed with regard to the TVTTM Retropubic, and you put those in the report and signed the report, correct?

A. Yes.

Q. In the course of the report, you talk about certain facts, certain articles, other things that you were considering.

Are those the things that you felt were most important to you, the factual things that you talked about in the report, that were most important to you in forming your opinions?

MS. KABBASH: Objection.

MR. SLATER: I'll tell you what I'm getting at.

BY MR. SLATER:

Q. In your report, you -- new question.

In your report, you recite various facts, things that you know from your background and

you talk about a lot of specific facts and literature and things like that.

Were those the facts that you felt were most important to you in forming your opinions that you set forth in the report?

A. Well, I wrote in my report the facts that I thought supported my opinions, yes.

Q. Exhibit-5, which is your case-specific report --

MS. KABBASH: Are you trying kill something?

MR. SLATER: I just killed a bug. You have an extermination issue here.

BY MR. SLATER:

Q. Exhibit-5, which is your case-specific report regarding Mrs. Corbet is dated July 13, 2014, correct? On Page 39, the last page?

A. Thank you.

Yes.

Q. That report contains each of the opinions you formed with regard to Mrs. Corbet, correct?

A. Yes.

Q. In the course of that report, you set forth various facts.

Were those the facts that were most important to you in forming those opinions?
A. Yes.
Q. Exhibit-6 is what you said is your supplemental report regarding Mrs. Corbet.
Why did you write that report?
A. Because that was after my medical exam -- medical examination was performed.
Q. You didn't only talk about your medical exam, though; you talked about other things in the supplemental report as well, correct?
A. Right. Because there were newer things that had come to my attention; depositions that I had read, specifically plaintiff's deposition. I felt the need to speak my mind about those.
Q. So the supplemental report contains any additional opinions that you formed when you saw the materials listed in that report, as well as your exam?
A. Exactly.
Q. And --
A. And there were also some newer studies that had come out that I wanted to review.
Q. Newer studies that weren't available

when you wrote your initial report in July of 2014?
A. I don't -- I'm trying to think if the Ford had come out by then.
Yeah, I was constantly reviewing literature. And then when things came out, I would put them in the newer supplement of the report.
Q. Your supplemental report regarding Mrs. Corbet is dated November 16, 2015, correct? That's on Page 24.
A. Yes.
Q. With regard to Mrs. Corbet, if I were to look at your initial report of July 13, 2014, and your supplemental report, dated November 16, 2015, that would be the sum of your opinions regarding Mrs. Corbet?
A. Yes.
Q. And the facts described in those two reports are the key facts on which you're basing your opinions, correct?
A. Yes.
Q. Exhibit-7 is a list of materials that you reviewed, that's what it says.
This was updated from the list that was attached to your initial general report --
A. Yes.

Q. -- which was Exhibit-4?
A. Uh-huh, yes.
Q. You did not write a supplemental general report, correct?
A. No. It's all included in here. Everything I reviewed. No, I never wrote a supplemental general report.
But the -- I believe that these are all compiled of the general and supplemental reliance list.
Q. Okay. Let me understand.
The Exhibit-7, which is your updated reliance list, when was this finalized, do you know?
A. Just recently. In the last few days.
Q. Because I think we just got it in the last week, I think.
MS. KABBASH: Yes.
MR. SLATER: So it was served some time in the last week?
MS. KABBASH: Right.
BY MR. SLATER:
Q. The only general report you've written is the general report that was served July 8, 2014, correct?
A. Right.

Q. Looking at Exhibit-7, you have a list of treatment records for Mrs. Corbet.
Those are the medical records you've reviewed and relied on, correct?
A. Yes.
Q. There's a list of -- if you go to the third page of your supplemental list of materials, a list of company documents that goes from about the third to the sixth page; it's 56 items.
A. Yes.
Q. Did you read all those materials?
A. I read as much as I could. I perused some and I read others more thoroughly. But if it's on the list, I had had an opportunity to look at it at some point.
Q. There's a list of deposition transcripts and Exhibits 1 through 12.
Have you read each of those transcripts and the exhibits to those depositions?
A. Again, some I've perused and some I've read more thoroughly. But, yes, I'm familiar at some -- at some level with all of these.
Q. Well, you're not saying you read all these transcripts cover to cover are you?
A. It's not possible, really.

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Q. You're not saying you read all the exhibits, correct?
A. I mean, I can tell you that I've done my best to read almost everything that's in this reliance list.
Q. No, I understand that.
Here is what I'm getting at --
A. Yes.
Q. -- with regard to the deposition transcripts and exhibits, you haven't read them all cover to cover, correct?
A. With few exceptions, I pretty much have, yeah. I can't say that I committed them to memory. But I've definitely looked at them.
Q. The publicly sourced documents list is 37 items.
And those are professional society statements and other FDA statements, things like that, correct?
A. Yes.
Q. Number 36 on that list is a Premarin® advertisement, right?
A. Yes.
Q. Premarin® is an -- is an estrogen cream?

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A. Yes.
Q. There's never been a study that's actually established that the use of estrogen on the vaginal wall will actually make a difference in healing an erosion, correct? It's never been established, right?
A. It is a first-line therapy for a vaginal mesh erosion.
Q. It's never been established that it actually makes a difference, right?
A. I'm not sure of that.
Q. There's no study you can point to that's actually established that, correct?
A. No, I can't point to a study.
Q. You know, just talking to the company documents, you were given these company documents, you looked at them.
But I think you told me before your opinions are based on your experience, your training and the literature, correct?
A. For the most part, yes.
Q. Before you told me that was the basis for it.
A. Yes.
Q. Is that changing now?

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A. No, no. I'm agreeing with you.
Q. Okay. The company gave you some internal documents, but that -- they didn't impact your opinions, right?
A. No. They don't impact my opinions, but I've looked at them.
Q. If there was deposition testimony given by Ethicon witnesses that could potentially undercut the basis for your opinions, would you have wanted to see those?
MS. KABBASH: Objection.
THE WITNESS: I don't know how deposition testimony could undercut the basis of my opinions.
BY MR. SLATER:
Q. Okay. There's a list of expert reports that you reviewed.
Did you review Dr. Klinge's expert report?
A. If it's on here, I reviewed it.
Q. I want to know, did you read it? Do you remember reading Dr. Klinge's expert report?
A. What page are you on?
Q. I'm on the page that says, Expert reports.

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A. Oh, we're after this.
MS. KABBASH: Note to self, put page numbers on list of materials reviewed.
THE WITNESS: I'm sure I reviewed it. I can't tell you I've committed it to memory.
BY MR. SLATER:
Q. Do you know who Dr. Klinge is?
A. Yes, a histopathologist.
Q. Do you remember anything about what he said in his report?
A. You'd have to give me a specific question about it, and then maybe it would come to memory.
Q. Do you remember anything he said in his report?
A. I can remember certain things, but I can't give you anything verbatim.
Q. What can you remember that he said in his report?
A. Nothing offhand that I can remember directly.
Q. There's a list of medical literature, and it goes to 160 entries.
Is that the medical literature that you are -- that you have reviewed in connection with

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your opinions?
A. Yes.
Q. Do you consider yourself to be an expert with regard to the material science of the mesh material in the TVTTM Retropubic?
A. I'm not a materials expert, but I'm very familiar with the mesh, as I use it on a daily basis.
Q. Have you ever studied, from a material science perspective, the mesh?
A. No, but it's my medium that I work with.
MR. SLATER: Move to strike from "but" forward on both of those answers, the last two.
BY MR. SLATER:
Q. Have you ever participated in a study of the mesh material from a histopathologic standpoint, under a microscope?
A. No.
Q. With regard to the histopathology of the mesh material, do you defer to those people who are pathologists who study that?
A. Yes. But I'm not as interested in the histopathology of what's going on with the mesh.

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I'm more interested in the clinical outcomes of the mesh, because I am a clinician.
MR. SLATER: Move to strike from "but" forward.
BY MR. SLATER:
Q. Do you know -- rephrase.
The Nilsson studies are set forth in your list here.
Do you know where those patients came from?
A. The original Nilsson patients?
Q. The Nilsson patients --
A. Scandinavia.
Q. The Nilsson patients that he studied and kept having these serial reports on?
A. Right. They were Scandinavian.
Q. Were those patients that are studied in the Nilsson study, were they studied in any other studies?
A. It was the same patients that were being studied in multiple studies going forward. We have 5-year data, 7-year data, 11-year data, 17-year data on those same group of patients.
Q. This is my question: The patients who are -- who are discussed in Nilsson's serial

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articles at different time points up through 17 years, do you know if those same patients are also described and studied in another study that's not the Nilsson study?
A. I do believe that they were. The Olson study, maybe. But I'm not entirely sure of that.
Q. Do you know the selection process for the patients in the Nilsson study? How they were selected to be studied?
A. They were the patients who were -- underwent the original TVT.
Q. Do you know how they were selected to be the ones that would actually be included in the study going forward?
A. I'd have to look at the study.
Q. Do you know if they were randomly selected?
A. I'm not sure, but I can look at the study and let you know.
Q. I am going to tell you -- let me ask you this: Is there any indication you're familiar with that the patients in the Nilsson study were randomly selected or that they were even consecutive patients that came for treatment? Do you know if

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any of those criteria were met?
MS. KABBASH: Adam, you're asking her questions -- I mean, I mean if you want to ask her from her rote memory --
THE WITNESS: Yeah, can I look --
MR. SLATER: That's all I'm asking. I know the answer, so I don't really care.
THE WITNESS: But I would prefer to look at the study so I can give you that answer.
MR. SLATER: Do you have it sitting right there?
BY MR. SLATER:
Q. I mean, I really don't want to take a lot of time, because I -- let me ask you this --
MS. KABBASH: It's up to you, but it's an unfair question to ask --
BY MR. SLATER:
Q. Let me ask you this --
MS. KABBASH: -- without the study sitting in front of her.
BY MR. SLATER:
Q. Let me ask you this --
A. Yes.
Q. -- if, in the Nilsson study, the patients were carefully selected and were not

randomly consecutively selected, that can introduce a bias into the study, correct?
A. I am not sure about that. Because they were the first TVT patients, they were 100 patients, no matter what the selectivity of that was. I would be comfortable with that.
Q. Do you know whether or not Nilsson actually decided which patients to include in his study?
A. You mean whether they had prolapse or -- I mean, they were excluding patients who had certain things, confounding features, but they were genuine stress incontinence patients.
Q. Do you know if there were additional patients available that Nilsson could have included in his study but chose these, based on some criteria known to him?
A. No.
Q. I saw earlier on in this list that you saw the deposition of Dr. Naber?
A. Yes.
Q. Do you know who that is?
A. Yes.
Q. Who is he?
A. He is -- I don't know what his exact

role in AUGS is, but he -- he's been very active in pelvic mesh.
Q. And what about his deposition was significant to you?
A. I mean, nothing -- nothing stands out as significant. I remember a lot of questions about biases and financial disclosures and that kind of thing.
Q. Does that matter to you, those types of things?
A. No, not really.
Q. Does it matter to you who wrote the AUGS statements about mid-urethral slings? Does it matter whether the people who authored those were being paid by industry as consultants?
A. No, it doesn't matter to me.
Q. Does it matter to you whether Ethicon is a member of AUGS?
A. When we have duties as physicians to put forth ideas that are based on science and Level 1 evidence, it doesn't matter to me whether Ethicon is present at a meeting or not.
Q. Did you read the AUGS statement cover to cover?
A. Yes.

Q. Did you read all the references to see if they actually are accurately referenced?
A. Yes.
Q. Did you read, in the statement itself, when it would reference something, to see whether or not what it said in the statement actually was accurately referencing what the reference stands for?
MS. KABBASH: Objection.
BY MR. SLATER:
Q. Did you actually match that up?
MS. KABBASH: Objection.
THE WITNESS: I don't really understand the question, counselor.
BY MR. SLATER:
Q. You look at the statements by AUGS, for example?
A. Yes.
Q. And they say X, Y, Z about the mid-urethral sling, and then they cite some article, for example.
Did you actually go to the articles and see what they actually say to see if what they were being referenced for, if there was a match?
A. In many cases, yes.

Q. Not all?
A. In most cases.
Q. Did you find anything in the AUGS statement where they cited a reference and then if you looked at the reference, you said, well, it doesn't actually stand for that proposition?
A. No, I didn't find that.
Q. Did you see any references in the AUGS statement where you saw the reference and said, you know, this isn't the whole story, the reference also says some other things that may cut the other way and they didn't mention that?
A. I don't really know what you're referring to. I can't answer these kind of vague questions that you're asking me.
Q. Well, I'm asking about your process as an expert. Because you want to be really thorough, right, as an expert?
A. Yes.
Q. In fact, you should be held to the standard of being incredibly thorough before you're going to walk into courtroom, in front of a jury, and you should be extremely thorough, right?
MS. KABBASH: Objection.
THE WITNESS: I agree with that.

BY MR. SLATER:
Q. And if you give an opinion, for example, that a statement by a professional society is important to you, you want to be able to tell the jury, I read that statement, I read all the references, and this is an accurate and a fair portrayal of those references that they're relying on? You need to be able to say that, right?
MS. KABBASH: Objection.
THE WITNESS: Yes.
BY MR. SLATER:
Q. The same would hold true with regard to the AUA statements, right?
A. Yes.
MS. KABBASH: Same objection.
BY MR. SLATER:
Q. Now, in this winding road that we're going to continue down, a long time ago, I started to ask you about February 19, 2012, the date that Mrs. Corbet was seen by Dr. Harrell, one of the dates.
And I asked you a question, and you wanted to refer to your report to be able to answer the question.
So if you want to turn to that date

in your case-specific report, we can come back to where we were.
You have a chronological --
A. Right. Right.
Q. -- you have a chronological --
A. It's coming back.
Q. -- statement of all her --
A. I do.
Q. -- office visits, et cetera?
A. I do. So let me go to that.
February 12th, 2012, you said?
Q. February 19th, 2012.
A. Okay.
Q. On February 19, 2012, according to your report, Dr. Harrell did an exam and found normal vaginal mucosa, correct?
MS. KABBASH: Do you mean the 29th?
THE WITNESS: What page are you on in my report?
MS. KABBASH: Do you mean the 29th?
BY MR. SLATER:
Q. I'm not in your report. I'm in my notes about your report. Did I write the wrong date?
A. I don't have that specific date.

MS. KABBASH: We have a February 29th, 2012.
MR. SLATER: Maybe I mis -- what page is it on?
MS. KABBASH: Page 12 at the top of the page.
MR. SLATER: Maybe I wrote the wrong date in my notes. Trying to mess with you here.
Yes, there you go. February 29th. See, look at that. Sorry about that.
THE WITNESS: Now I'm on board.
BY MR. SLATER:
Q. On February 29, 2012, Dr. Harrell examined Mrs. Corbet and found normal vaginal mucosa, correct?
A. Uh-huh.
Q. That means there's no vaginal atrophy, correct?
A. No, that doesn't mean that. Just normal vaginal mucosa means that it could be -- atrophy could be normal for someone Mrs. Corbet's age.
Q. Did Dr. Harrell note any vaginal atrophy on February 29th, 2012?
A. Not that he writes in the report.

Q. Dr. Harrell wrote that Mrs. Corbet had normal vaginal mucosa?
A. Yes. But those are not mutually exclusive.
MR. SLATER: Move to strike from "but" forward.
BY MR. SLATER:
Q. When a patient has atrophy, do you note that they have normal vaginal mucosa in your records?
A. Sometimes, yeah, I could.
Q. When you mean that it's normal for that patient?
A. It's normal for that patient, it's normal for that age. Atrophy is normal in someone -- in someone Mrs. Corbet's age.
Q. So you think that you don't -- you can say normal for anyone her age and that means atrophy, even though all women her age don't have atrophy?
A. Most women Mrs. Corbet age have some degree of atrophy, so I would consider that to be normal.
Q. Do they all?
A. Almost all. Once you lose your

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estrogen, you get atrophy. And she lost her estrogen.
Q. On May 18, 2012, Mrs. Corbet complained of bladder spasms, correct?
A. Yes.
Q. That's the first indication I saw of bladder spasms.
Is that consistent with your reading of the records?
A. That's not the first indication of bladder spasms. It's just the first indication of the word "bladder spasms."
Q. That's what I'm asking you.
A. Of the word "bladder spasms," yes. But there are -- there's evidence in the record of bladder spasms earlier than that, even before her surgery.
Q. When you say there's evidence of bladder spasms earlier in the record, you are saying that there are clinical symptoms being reported that are consistent with bladder spasms?
A. Yes. And a questionnaire where she -- where she documents that she's having bladder spasms and having difficulty making it to the bathroom.

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Q. Did Mrs. Corbet ever report bladder spasms before the TVT surgery?
A. She didn't use the word "bladder spasms."
Q. That was my question.
A. She did not use the word "bladder spasms."
Q. On May 18, 2012, a medication called Gelnique, G-E-L-N-I-Q-U-E, was prescribed.
What is that for?
A. That's for overactive bladder.
Q. After Mrs. Corbet started taking the Gelnique, she started to complain of dry mouth and vaginal dryness, correct?
A. Yes.
Q. Those are side effects of that medication?
A. Dry mouth, yes. Vaginal dryness is really more of a sign of atrophy. You don't see a lot of vaginal dryness from overactive bladder medicines.
Q. You do or you don't?
A. No, I don't.
Q. Can it happen?
A. Well, I've never seen it before, and

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I don't think it's ever been reported.
Q. Was Mrs. Corbet complaining of vaginal dryness before she started taking the Gelnique?
A. I'm not sure. It's not documented in the record, but she might have been.
Q. Doctor, I'm only asking you what you've seen. So --
A. Right. It's not documented in the record that she had -- that she complained of vaginal dryness.
Q. On February 19th, 2013, Dr. Smith performed surgery to remove eroded mesh, correct?
A. Yes.
Q. The pathology has certain findings --
A. Can I just -- can I just comment? It wasn't eroded. It was exposed. We have to be careful with our terminology.
Q. It eroded through the vaginal wall, right?
A. But we don't use the word "erosion," --
Q. Who is "we"?
A. -- we use the word "exposure."
Q. I use the word erosion. So we use

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all sorts of terms.
A. It's just not a technically -- the it's not the medical term --
Q. Really?
A. -- for exposure.
Q. Really? Aren't there a lot of doctors that talk about mesh erosion through the vaginal wall?
A. But you'd have -- you'd have to really be careful with that, because erosion really refers to -- and even that term is out of favor, but erosion refers to going through the lumen of an organ, which is not what happened here.
Q. Is that because the people who are working with the mesh manufacturers want to make it sound like it's not a big deal?
MS. KABBASH: Objection. Adam, come on.
BY MR. SLATER:
Q. Isn't that -- isn't that what's going on? Isn't this more of a --
A. It's really not.
Q. -- mind meld by these highly-paid marketers that are influencing the doctors they pay tens of hundreds of thousands of dollars every year?

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MS. KABBASH: Objection.
THE WITNESS: Not at all. That's ICS terminology.
BY MR. SLATER:
Q. Who on ICS is being paid by industry, do you know?
MS. KABBASH: Objection.
THE WITNESS: There are plenty of people who are making decisions who are not paid by industry, who are doing trials and they are studying their own patients and it has nothing to do with industry.
BY MR. SLATER:
Q. Okay. That's great.
The mesh caused some reaction with the tissue such that the mesh came through the vaginal wall into the vagina, right?
A. No, I don't know that that's the case.
Q. The mesh miraculously appeared within the vagina one day without having gotten through the vaginal wall; is that your testimony?
MS. KABBASH: Objection.
THE WITNESS: No. That's not -- my testimony is that I'm not sure how the mesh became

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exposed. But I'm not going to say there was some reaction that caused the mesh to become exposed.
BY MR. SLATER:
Q. That's fine. You don't have an opinion as to the mechanism by which the mesh became exposed into the vagina, correct?
A. I have an opinion on the possibilities of why mesh becomes exposed in general.
Q. I'm not asking in general.
In Mrs. Corbet, you're not offering an opinion as to why the mesh -- the mechanism by which the mesh got through the vaginal wall and was exposed in the vagina, correct? Is that what you just told me?
A. I'm not sure that I'm not offering an opinion for the mesh exposure on Mrs. Corbet.
Q. You just told me that?
A. Well, can we -- can we play it back so I can see what you were saying?
Q. Doctor, it's very simple.
Are you giving me an opinion right now as to the mechanism by which the mesh in Mrs. Corbet through the vaginal wall and was exposed into the vagina?

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A. I'll give you an opinion on the possibilities of how the mesh became exposed. I cannot say for sure how the mesh became exposed.
Q. Well, I don't want a list of possibilities. I want to know if you have an opinion as to what occurred?
A. I have an opinion that it did not occur because of reaction of the mesh to the vaginal wall. That you -- this is what you stated before.
Q. So you think the mesh came through the vaginal wall; it was not due to a reaction between the mesh and the tissue?
A. Right.
Q. But it came through some other way.
Tell me the other possible ways.
A. Probably, it had to do with the placement of the sling.
Q. Yeah, what's that?
A. Well, I think if the sling is placed too thinly -- there's lots of reasons why mesh can become exposed. But if the sling is placed too thinly under the vaginal wall, we do see exposures.
Q. What other possibilities?
A. It depends on the exposure. I mean, sometimes we see that the -- that the stitch over

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the sling becomes violated, and the vaginal wall opens, revealing the sling underneath.
Q. Is there some indication of a stitch here?
A. This is in general. This is not in Mrs. Corbet.
Q. All right. Let me -- let's be really clear. I don't care about general reasons why mesh exposures or mesh erosions through the vagina occur, okay? I've read all the same stuff.
So here is my question: As you sit here now, are you offering an opinion as to the mechanism by which the TVT mesh in Mrs. Corbet became exposed into the vagina?
A. I'm offering an opinion that it may have had to do with the placement of the sling and how -- the technical error of how the sling was placed, which is something that happens when slings are placed and is warned about.
Q. You're saying that may have been, but you're not saying that more likely than not that that occurred, correct?
A. More likely than not.
Q. So you're blaming Dr. Harrell for a thin placement of the mesh? Where does it say that

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in your report?
MS. KABBASH: Objection.
THE WITNESS: I am saying that most of the mesh exposures that happen have to do with technical error. And it's not a blame of a doctor, it's just --
BY MR. SLATER:
Q. Is there anywhere in your report --
MS. CRAWFORD: I don't think she was finished with her answer, Adam.
MR. SLATER: Oh, I thought you were.
MS. KABBASH: You have to let her finish the answers.
BY MR. SLATER:
Q. Go ahead.
A. What I'm saying is when mesh becomes exposed in the area that is exposed, it usually has to do with technical placement of the sling and not the sling itself.
It's not a blame, just one of the things that happen.
Q. So that's a generalization, right?
A. But more likely than not, that's what happened here.
Q. Show me in your report where you say

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there was any technical error by Dr. Harrell and how he placed the TVT?
A. I don't have --
MS. KABBASH: Objection.
THE WITNESS: I don't say that in my report. But you're asking me what my opinions are, and that's my opinion.
BY MR. SLATER:
Q. You told me earlier your report contained each of your opinions, right?
A. Yes.
Q. So now you have a new opinion that Dr. Harrell committed a technical error in how he placed the mesh?
A. I never said that Dr. Harrell -- you're mincing my words.
I never said he committed a technical error. I said it's a technical placement of the sling, where the sling can be too thin underneath the vaginal -- underneath the vaginal wall. And that is something that we all know about when we place slings, it's warned about in the IFU.
Q. It's warned about in the IFU that a superficial placement of the mesh can lead to an erosion?

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A. Erosion -- that exposures can happen, is warned about in the IFU.
Q. There's nothing about superficial placement mentioned in the IFU causing erosions; it doesn't say that, right?
A. No. But that's something that we all know who do slings on a regular basis.
MR. SLATER: Move to strike from "but" forward.
BY MR. SLATER:
Q. Doctor, I understand that you're telling me in general that there's reasons why things can happen.
So I want to talk about Mrs. Corbet and a case you're actually going to sit on a witness stand in January on, okay?
A. Sure.
Q. So here is the question: Show me in your report any criticism of Dr. Harrell whatsoever.
A. I don't criticize Dr. Harrell whatsoever.
Q. And as you sit here now, you have no criticisms of Dr. Harrell, correct?
A. I would never have a criticism of a known -- a known possible risk --

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MR. SLATER: Move to strike.
THE WITNESS: -- of a complication of a --
MS. CRAWFORD: You have to let her finish. You can move to strike all you want to, but you've got to let her finish her answer.
MR. SLATER: I just want an answer to my question. We're never getting out of here, by the way, that's the answer to that. We will be eating dinner in New York tonight.
MS. KABBASH: Fine. Just wait until she gets to the end of her answer before you do whatever.
BY MR. SLATER:
Q. As you sit here now, you have no criticisms of Dr. Harrell, correct?
A. Right.
Q. If mesh is placed thinly or superficially, for the mesh to become exposed into the vagina, it has to come through the vaginal wall, correct?
A. Yes.
Q. As you sit here now, in this case, you have no indication that Dr. Harrell placed the mesh thinly or superficially? There's no indication

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in his operative report? There's no indication in the findings after the surgery? There's nothing that indicates that, correct?
A. Only that it happened.
Q. Mesh exposure, as occurred in Mrs. Corbet, can happen even if the mesh is not placed superficially or thinly, correct?
A. I disagree with that statement.
Q. You think that's the only way that can happen?
A. Yes.
Q. Really?
A. I think it's -- in that area, in the lateral sulcus, it's just too thin. And that's what I believe.
Q. You believe that if the mesh was placed at a depth that you think is the depth it should be at, that it couldn't erode through the vaginal wall and be exposed?
A. Right.
Q. Have you ever treated a mesh exposure in the lateral sulcus where the arms are?
A. Yes.
Q. You didn't know whether the mesh was placed superficially or not at that time, did you?

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A. Yes.
Q. How did you know?
A. Because it had exposed.
Q. So you think the only way mesh can become exposed, where the arms are located, is because it's placed thinly?
A. Yes.
Q. Do you know what Ethicon thinks about that?
A. I'm not really interested in what Ethicon thinks about that. I'm interested in what I know and what I've talked to about my colleagues with.
Q. Have you had erosions or exposures of mesh that you put into a woman's body in the area where Mrs. Corbet had the exposure?
A. Yes.
Q. So you placed it thinly in those cases, right?
A. It's happened, yes.
Q. So even when one follows the TVTTM Retropubic procedure exactly, as people are trained on, and can be a very high-level surgeon, it can happen that it can be placed at different depths; that just can happen because everyone's body is

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different and every surgery is different, correct?
MS. KABBASH: Objection.
THE WITNESS: Yes. And it's warned about.
MR. SLATER: Move to strike from "and" forward.
BY MR. SLATER:
Q. It's your testimony that it's -- you believe that the mesh was placed closer to the surface than -- rephrase.
You're telling me that you think the mesh was placed thinly below the surface of the vaginal wall and that's why it became exposed, correct?
A. Yes.
Q. Do you have an opinion, to a reasonable degree of medical certainty, of how it was that the mesh got from behind the wall to the vaginal side of the wall so that it was exposed?
MS. KABBASH: Objection.
THE WITNESS: When we place mesh too thinly and we slit the thickness of the vaginal wall, mesh is more likely to become exposed. That's why we all know, in our training, and we're all trained to do these procedures now, that we need to

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do full thickness placement of the mesh.
MR. SLATER: Move to strike.
BY MR. SLATER:
Q. I'm not asking about the effect of the mesh being exposed. I'm talking about in Mrs. Corbet's case, what occurred. So let me start again.
In Mrs. Corbet's case, are you offering an opinion, to a reasonable degree of medical probability, of the mechanism by which the mesh came through the vaginal wall?
A. I'm offering my -- my opinion that it was either placed too thinly, if it wasn't already placed at that level to begin with, as by the granulation tissue he saw within the first month or two after examining her.
Q. Meaning the granulation tissue being related to the mesh?
A. Possibly, because it was placed too thinly.
Q. And what about the mesh causes the granulation tissue?
A. The granulation tissue is just a sign of wound healing, and that there was something about that area where there may have been an exposure.

Q. Granulation tissue can be a precursor to an erosion, correct?
A. It could be, yes. But not an erosion, an exposure.
Q. I'm going to try this one more time. Do you have an opinion, as you sit here now, as to the mechanism by which the mesh came through the vaginal wall and was exposed into the vagina?
MS. KABBASH: Objection.
BY MR. SLATER:
Q. What actually occurred such that the mesh, which was behind the vaginal wall, was then not behind the vaginal wall? Do you have an opinion as to what occurred?
A. If it was behind the vaginal wall to begin with, it was placed so thinly that that small amount of vaginal wall that was over the mesh was unable to live long enough, so that the mesh would expose. That's my opinion. And that's how mesh exposures happen.
Q. When Dr. Harrell observed, on physical exam, a normal vaginal mucosa, that would indicate that there was no mesh exposed into the

vagina, right?
A. Assuming that he looked in that area, yes.
MS. KABBASH: Objection.
BY MR. SLATER:
Q. You said something just before, assuming the mesh was actually placed behind the vaginal wall. Are you saying you think it may have been actually placed where it was exposed into the vagina from the beginning? Is that -- are you actually offering that as a possibility?
A. It's not out of the realm of possibility.
Q. So you're saying Dr. Harrell may have placed the mesh, actually exposed into the vagina with the left arm exposed into the vagina, and not noticed that?
MS. KABBASH: Objection.
THE WITNESS: It's happened before.
BY MR. SLATER:
Q. Has it happened to you?
A. It's happened.
Q. Has it happened to you?
A. Yes, it's happened to me.
Q. You've actually placed a TVT with an

arm exposed into the vagina and you didn't notice it for months and months and months, that you had placed it not even behind the vaginal wall?
MS. KABBASH: Objection.
THE WITNESS: It can sometimes be very subtle. But, yes, it can happen.
BY MR. SLATER:
Q. Are you offering an opinion, to a reasonable degree of medical probability, that Dr. Harrell placed the mesh and it wasn't even behind the vaginal wall to begin with? Are you actually saying that's what occurred?
A. I am saying it's not out of the realm of possibility.
Q. There's a lot of possibilities, right?
A. Yes.
Q. One possibility is that Dr. Harrell placed the mesh in accordance with the TVTTM Retropubic procedure, followed the procedure correctly, and the mesh came through the vagina, for whatever reason was exposed into the vagina; it is possible that he did the procedure as instructed, correct?
A. It's unlikely.

Q. When you place the mesh in your own patients and it was thinly -- and it was thin, as you called it, and it then came through the vaginal wall, did you follow the TVT procedure?
A. Yes.
Q. So one can follow the TVT procedure and the mesh can be placed thinly, even though you followed the procedure correctly, right?
A. Yes.
Q. And when that happens, that increases the risk of a mesh exposure into the vagina, correct?
A. Right. So about 1 to 2 percent of --
Q. I didn't ask you statistics.
MS. KABBASH: Hang on, Adam. Let --
MR. SLATER: Are you actually asking your expert to start throwing statistics at me right now?
MS. KABBASH: I don't know what she's about to say, because you didn't let her to finish. So let her finish.
MR. SLATER: There wasn't even -- there wasn't even a new question pending.
MS. KABBASH: You asked her when that happens, that increases a risk of a mesh exposure

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into the vagina, correct?
MR. SLATER: And she said right. And that was -- she answered the question.
MS. KABBASH: And she was about to say something. So let her say it.
MR. SLATER: Go ahead. I'll strike it.
BY MR. SLATER:
Q. Go ahead. Tell me statistics I didn't ask for.
A. In about 1 to 2 percent of cases, we see mesh exposures in the vagina.
Q. It's your testimony that the mesh exposure rate for the TVTTM Retropubic is 1 to 2 percent?
A. In experienced hands, over the long -- over the long-term data, yes; maybe as high as 3 percent.
Q. Experienced hands.
What does that mean?
A. People who are following the procedure, who have been well trained to do the procedure, after their learning curve, will have about between a 1 and 3 percent rate of mesh exposure. And that's probably what I see in my own

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practice.
MR. SLATER: I move to strike.
BY MR. SLATER:
Q. Was Dr. Harrell an -- were his hands experienced hands?
A. I assume he was. He's done a fair amount of slings.
Q. I saw in your report you said you're not a pathologist, but you looked at the pathology report.
Are you -- is that basically saying, I'm not an expert in pathology but I can tell you what I think this means?
A. Yes.
MS. KABBASH: Objection.
THE WITNESS: I'm not a pathologist.
BY MR. SLATER:
Q. Do you know whether or not a foreign body giant cell reaction is an indication of a chronic foreign body reaction?
A. I believe that that's what a chronic foreign body reaction definition is.
Q. The pathologist found a foreign body giant cell reaction and chronic inflammation in the tissue that was removed with the mesh, correct?

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A. Which pathologist is this?
Q. Whoever looked at the pathology that was taken from the surgery by Dr. Smith.
That's what the hospital pathologist saw, right?
A. The hospital pathology? Do I have that report? I know that's in my --
MS. KABBASH: It's in your --
BY MR. SLATER:
Q. On Page 14 of your report --
A. Okay.
Q. -- it says, The pathology report references skin and fibroadipose tissue with mesh and associated foreign body giant cell reaction and chronic inflammation.
A. Right. Okay. Exactly.
Q. That's what was found by the pathologist at Penn, right?
A. Right.
Q. And that's consistent with a chronic foreign body reaction and a chronic inflammatory response, correct?
A. Okay.
Q. Is that correct?
A. That's correct.

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Q. On August 19, 2013 -- I'm just walking through your report.
On Page 15, you say, Physical exam showed tenderness in the left fornix of the vagina without exposed mesh or erythema.
Right?
A. Yes.
Q. That's where the mesh had been removed, correct?
A. Presumably, but I can't be sure.
Q. That's the area where you found tenderness on your exam, correct?
A. That's the area that I found tenderness on my exam.
Q. The TVT procedure that Mrs. Corbet had, that can make one's urge incontinence more refractory to treatment than it was before the procedure, correct?
MS. KABBASH: Objection.
THE WITNESS: Can you repeat that question?
BY MR. SLATER:
Q. You know what refractory to treatment means, right? It means it's harder to treat, right?
A. Uh-huh.

Q. The TVT procedure Mrs. Corbet had can make an urge incontinence condition more refractory to treatment than it would have been, but for the TVT procedure, correct?
A. No, I disagree with that.
Q. The TVT procedure could have exacerbated or made Mrs. Corbet's urge incontinence more persistent, it's possible, right?
A. I don't think there's any evidence of that in the record.
Q. Mrs. Corbet's urge incontinence persisted despite medications, correct?
A. She was -- she was helped by medications significantly. It did not go away. But we never tried medications before her sling procedure, so we don't know whether it was refractory then or not.
Q. Mrs. Corbet ultimately was complaining of frequency, correct?
A. Right. But she was complaining of that also before, urgency before --
Q. I didn't say urgency --
A. -- and the need to go to the bathroom.
Q. -- I said frequency.

Frequency is different than urgency, right?
A. Yes. They often go hand-in-hand.
Q. They often do. But Mrs. Corbet didn't complain of frequency before her TVT surgery, did she?
A. Not entirely sure about that. I know she complained of urgency and overactive bladder symptoms.
Q. Is there any indication in your report that Mrs. Corbet had frequency before the TVT procedure?
A. More urgency.
Q. You don't mention frequency preoperatively, do you?
A. More urgency than frequency.
Q. It's simple.
You don't mention frequency before the TVT procedure, do you?
MS. KABBASH: Objection.
THE WITNESS: I probably mention urgency more than frequency, because that's what she was complaining of more.
BY MR. SLATER:
Q. You understand what you're doing.

You keep saying, I mentioned urgency more than frequency; and what I keep saying is, you didn't mention frequency in your report as a condition Mrs. Corbet had preoperatively; is that true?
A. It's probably true that I didn't say the word "frequency."
Q. In your report, you talked about the extent to which complaints by Mrs. Corbet were either made or documented, with various positions as she went through her care after the mesh was removed, right?
A. Yes.
Q. As you sit here now, am I correct, you're not disputing that Mrs. Corbet has had dyspareunia from after the surgery by Dr. Smith up to the present? You're not disputing that, are you?
A. No.
Q. The pelvic hematoma that she had, that likely resulted from the TVT procedure, right?
A. It's possible that that's what caused it, yes.
Q. Based on the location of where it was found on the MRI and the CT guided percutaneous drainage, it's in the proximity -- direct proximity to the TVT arm, isn't it?

A. It's in the retropubic space where the TVT would have traversed.
Q. It's actually in the left part of that space adjacent to the where the arm was, correct?
A. Right.
Q. The same arm that eroded, correct?
A. It was on the same side as the -- as the exposure.
Q. It's actually adjacent to that spot, right?
A. It's on the same side as the -- the hematoma and the exposure were both on her left side. Whether they are correlated or connected or not, I cannot say.
Q. Based on the description of the size and location of the hematoma, it likely was adjacent to and touching the mesh, right?
A. Possibly, yeah.
Q. Based on the location and size of the hematoma, as described on the diagnostic studies, the mesh and the placement of the mesh likely caused that hematoma to form, correct?
A. The procedure --
MS. KABBASH: Objection.

THE WITNESS: -- of doing a retropubic sling can cause a hematoma. So that procedure itself could have caused the hematoma, yes.
BY MR. SLATER:
Q. Most likely, that's the cause, right?
A. The procedure of doing the retropubic sling, sure, could have caused a hematoma.
Q. Well, most likely that is the cause, right?
A. Moth likely.
Q. And they only retropubic sling she had placed was the TVTTM Retropubic, right?
A. That's right. That's the procedure that she had performed to treat her stress incontinence.
Q. In your report, you talk about treating -- and this is on Page 29 of your case-specific report we've marked as Exhibit-5.
A. Case specific.
Q. Page 29, Exhibit-5. I just want to ask you about something.
A. Sure.
Q. You talk about patients having mesh exposure and complaining of dyspareunia, and then

when the exposed portion of the sling is removed, you've had patients who have resolution of their dyspareunia after that removal.
You're talking about that in your practice, right? That's what you're describing?
A. If dyspareunia is caused by an exposure, usually when you remove the exposure, the dyspareunia goes away.
Q. You say, I have witnessed this repeatedly in my own practice.
When you say the word "repeatedly," how many times are we talking about? That sounds like a lot.
A. When I --
MS. KABBASH: Objection.
THE WITNESS: When I have had a mesh exposure and I've removed the mesh exposure, and I can't give you a number on how many that is, it's not a great number, but it's enough that I can say with great certainty, that when you remove the exposure, if that's what is causing the dyspareunia, the dyspareunia will become better.
BY MR. SLATER:
Q. The exposure of mesh in Mrs. Corbet was not at the site of the incision, it was at a

different site, correct?
A. It was in the left lateral sulcus, which is not where the incision would have been.
Q. You indicate that TVTs are not difficult to remove in most cases. I want to ask you about that.
Are you talking about complete removal of the entire device?
A. For the vaginal portion all the way up to the retropubic space, it's quite easy to remove the TVT.
Q. This is what -- I want to understand vocabulary right now.
You say TVTs are not difficult to remove in most cases. When you say that, are you talking about the entire TVT?
A. I can take out the entire TVT. I don't find it very difficult.
Q. How many times have you removed an entire TVT device from a patient?
A. I haven't had to remove an entire TVT in more than maybe one -- one or two patients in my entire career.
Q. You indicate, Dissecting it gently off the surrounding tissues can be accomplished, in

most cases, quickly and without injury.
How many times have you done that?
A. I've probably done about ten or so -- between five and ten a year, removal of TVTs.
Q. Is that your patients only or other people's patients, too?
A. It's a combination. It's more others, but it's a combination.
Q. Five to ten per year for how many years?
A. Ten years.
Q. So 50 to 100?
A. Okay.
Q. You say that gently -- rephrase.
You say that you can dissect it gently off the surrounding tissues. That can be accomplished, in most cases, quickly and without injury, which means that in some cases that cannot be accomplished quickly and without injury, correct?
A. In some cases, right.
Q. In some cases, the removal of some portion of the mesh can be very difficult and can be morbid surgery, correct?
A. I would never say that it's morbid surgery. It's just more difficult in some cases.

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If it was ever imbedded in a place where it couldn't be reached, it would be harder to get it out.
But I can't say that I've ever had a case where I haven't been able to get it out.
Q. You say, at the very bottom of the page, When removed properly and entirely, the risk of further exposure is unlikely, allowing sexual comfort to return to normal.
Are you talking about -- when you say "entirely," are you saying the entire mesh, all the mesh in the body?
A. Well, usually, I'm referring to just the vaginal portion up to the retropubic space. It depends on what type of sling you're referring to.
Q. So this part of your report is not limited to the TVTTM Retropubic?
A. Well, you're asking me in general. But if we're talking about the TVTTM Retropubic specifically, we don't usually go above the pubic bone to get the sling out.
Q. This report is your specific report on Mrs. Corbet. So you're talking about the TVTTM Retropubic, right?
A. Yes.
Q. In Mrs. Corbet, mesh is still in her

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body, correct?
A. A small part on the right side and maybe up in the retropubic space, deeply, on the left side.
Q. Even on the left side, you can't tell me that there's no mesh, either mesh fibers or portions of mesh, left inside of her?
A. Above -- in the retropubic space, there probably is some, yes.
Q. Even where the left arm was operated, on, it's certainly possible that there are some mesh fibers or mesh material that was left behind, correct?
MS. KABBASH: Objection.
THE WITNESS: Probably. But it wouldn't have any clinical significance in her.
MR. SLATER: Move to strike from "but" forward.
BY MR. SLATER:
Q. Mrs. Corbet does have a risk -- I'm sorry.
Mrs. Corbet does have a risk of mesh exposure or mesh erosion from the remaining mesh going forward; that's a risk that exists, correct?
A. It's an infinitesimal risk.

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MR. SLATER: Move to strike.
BY MR. SLATER:
Q. Mrs. Corbet has a risk of mesh exposure or mesh erosion from the remaining mesh in her body, going forward?
MS. KABBASH: Objection.
BY MR. SLATER:
Q. That risk does exist, is that a correct statement; yes or no?
MS. KABBASH: Objection.
THE WITNESS: It's extremely unlikely, counselor.
MR. SLATER: Move to strike.
BY MR. SLATER:
Q. I'm asking for a yes or no. I'm not asking for percentages. I'm not asking for your intuition and on whether it's going to happen or not. I'm not -- that's not what I'm asking for.
So here is my question: Mrs. Corbet has a risk of mesh exposure or mesh erosion from the remaining mesh in her body, going forward; is that a true statement, that a risk exists?
MS. KABBASH: Same objection.
THE WITNESS: If I say yes to that, I just want to qualify that that is extremely

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unlikely.
MR. SLATER: Move to strike.
BY MR. SLATER:
Q. Am I correct that Mrs. Corbet has a risk of mesh exposure or mesh erosion from the remaining mesh in her body, going forward?
MS. KABBASH: Objection.
BY MR. SLATER:
Q. Is that a true statement that a risk exists, going forward; yes or no?
MS. KABBASH: Objection. Asked and answered.
THE WITNESS: I will not say yes without qualifying that it is extremely unlikely. I can't say -- then I'll just say, no, it's unlikely. It's not going to happen. I don't believe it's going to happen.
Because -- and I'm going to tell you why.
BY MR. SLATER:
Q. I haven't asked you. I mean, let me tell you how this works. I'm moving to strike what you just did. I'm going to ask to preclude your testimony at trial for not being willing to answer a very simple question. It hasn't been asked and

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answered.
I don't care --
MS. KABBASH: Four times, actually.
MR. SLATER: It actually has not been, Maha.
MS. KABBASH: It has.
MR. SLATER: What the doctor is doing is telling me a qualification on a yes or no that I've asked for.
MS. KABBASH: She is absolutely entitled to explain to you why she cannot answer your question.
MR. SLATER: When you question her.
MS. KABBASH: She is absolutely --
MR. SLATER: She can't --
MS. KABBASH: -- entitled to explain why she cannot answer it as a yes or no. That's precisely what she did, and she's entitled to do that.
BY MR. SLATER:
Q. Doctor, what you're doing is refusing to answer my question?
MS. KABBASH: That's not true.
MS. CRAWFORD: That's not what she's doing.

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BY MR. SLATER:
Q. You are.
A. I answered your question.
Q. No, you didn't.
A. I said that yes, but that it's extremely unlikely, and that's the only way that I'll say yes --
Q. All right. Well, I'm not asking you --
A. And I'll tell you why -- what that's based on.
Q. Honestly, I've read your report. It doesn't matter to me. I'm trying to move through a deposition. If they want to ask you whether it's likely or not, the two lawyers to your right will ask you that question when they get to question you, or they'll put you on the witness stand and you can then tell the jury all the reasons why she's never going to have a mesh erosion, in your opinion. You can do whatever you want. I just want to get a simple answer to a simple question, okay?
Do you agree with me that Mrs. Corbet has a risk of exposure or erosion in the future from the mesh that remains inside her body, going forward? Is there a risk; yes or no?

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A. Yes, but no more than anybody else that has a sling in their body.
MR. SLATER: Move to strike from "but" forward.
BY MR. SLATER:
Q. You say, on Page 36, It is not the role or responsibility of medical device companies which manufacture products to create surgical alternatives for patients.
Do you stand by that statement?
A. Yes.
Q. So if this jury were to find that Ethicon, a medical device company that manufactures products, actually set out to create surgical alternatives for patients to market to doctors and get doctors to want to use their product, that's not their role, according to what you said here, right?
MS. KABBASH: Objection.
THE WITNESS: If I clarify that statement, it's not their role to offer a Burch colposuspension or autologous facial sling to a patient. And that's what that paragraph is about.
BY MR. SLATER:
Q. Really? Where does it say that?
MS. KABBASH: What page are you on?

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BY MR. SLATER:
Q. Where do you say that? Where did you talk about a Burch colposuspension, Doctor?
MS. KABBASH: Which page are you on, Adam?
MR. SLATER: 36.
MS. KABBASH: Of which report, the general or --
MR. SLATER: The same one I've been asking about the last 20 minutes, Number 5. The case-specific report.
THE WITNESS: I was -- I was referring to Dr. Rosenzweig's testimony that she could have had a Burch colposuspension or autologous fascial sling, which is what I talk about in the paragraph above that.
BY MR. SLATER:
Q. Really? What --
A. Available to Ethicon such as a Burch procedure or autologous fascial sling, or other meshes. That's in Number 4.
Q. A medical device company shouldn't be out there trying to influence what the standard of care is, should they?
A. No.

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MS. KABBASH: Objection.
THE WITNESS: They shouldn't be.
BY MR. SLATER:
Q. They shouldn't set out to set a standard of care, should they?
MS. KABBASH: Objection.
THE WITNESS: No, they should be out to provide the best product that they can, the safest product and most efficacious product to women.
BY MR. SLATER:
Q. Should a medical device company like Ethicon be paying doctors and then carefully watching them, when they go to professional society meetings, to make sure that they're only giving positive information about the product that they want them to promote?
MS. KABBASH: Objection.
THE WITNESS: I am not sure what you're referring to there.
BY MR. SLATER:
Q. Should Ethicon have their marketing and salespeople at professional society meetings, like AUGS, and talking to their paid consultants who are going to speak at those meetings, to make sure

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they stay on message with a positive message about their products? Should that be going on?
MS. KABBASH: Objection.
THE WITNESS: I'm not going to speak to what Ethicon does or what Ethicon should be doing. It doesn't matter to me.
BY MR. SLATER:
Q. Okay. So if Ethicon did that, you don't care?
A. It doesn't -- it doesn't affect me or influence me if Ethicon is there or paying people to speak. That doesn't matter, they're a company.
Q. Doctor, you've put yourself in this case as a paid expert witness for Ethicon.
Do you understand that?
A. Yes.
MS. KABBASH: Objection.
BY MR. SLATER:
Q. So do you understand that whether something matters to you as a person when you walk out of being an expert is not what I am asking about?
This is you --
MS. KABBASH: Actually, it's exactly what you're asking.

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BY MR. SLATER:
Q. You put yourself out as an expert. So I'm asking all these questions as an expert witness.
You want to walk into a courtroom and say, I'm an expert witness, and I stand in front of Ethicon and say Ethicon did the right thing? Isn't that what you're doing?
MS. KABBASH: Objection.
THE WITNESS: Yes.
BY MR. SLATER:
Q. So if Ethicon went out and had their paid doctors at professional meetings, like AUGS, and actually were making sure they stayed on a positive message about the TVT when talking about doctors when they were trying to promote that and make that the standard treatment people would want to use in your field, you're okay with that?
MS. KABBASH: Objection. Asked and answered.
THE WITNESS: You're --
BY MR. SLATER:
Q. Are you okay with that?
A. I'm only okay because you're presuming that doctors will say things and do things

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because they're paid to do it, and not because they --
Q. You don't think that goes on?
A. I have to believe that in my professional society, that doctors have minds of their own and they are looking at the literature objectively, they're looking at their patients objectively and what's best for their patients.
Q. Are you -- if I could show you a document that showed that Ethicon actually was telling the doctors that they pay to make sure they stay with positive messages about the TVT at a professional society meeting, would you be perfectly fine with that?
A. I would never do a product --
Q. I didn't ask --
A. -- that I didn't think it was right for a patient because a doctor had told me that.
Q. That's you. That's great.
MR. SLATER: Move to strike.
BY MR. SLATER:
Q. Would you be okay with that?
MS. KABBASH: Objection.
BY MR. SLATER:
Q. I just want to know if you think it's

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a good thing to do or if you think maybe it's a little unsavory. Whatever you want to say. If you think it's fine, say it's good. I don't care. Just tell me.

A. I don't --

MS. KABBASH: Objection. And by the way, beyond the scope of the opinions --

THE WITNESS: I can't comment --

MS. KABBASH: -- in the expert report.

THE WITNESS: -- on the practice of the company. I can just tell you I think that doctors make decisions based on their clinical experience, on their training and review literature; and most of us don't pay a lot of attention to what a medical company tells us.

BY MR. SLATER:

Q. You made some comments in your report about Dr. Smith saying she didn't see evidence of either excessive contraction or excessive vaginal scarring.

You know you talked about that?

MS. KABBASH: What page are you on again?

MR. SLATER: It's all over. She

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talked about it several times. It's on Page 37, for example.

MS. KABBASH: Okay.

THE WITNESS: Okay.

BY MR. SLATER:

Q. What did Dr. Smith do to determine whether there was excessive contraction of the mesh? How did she study the mesh to determine that?

MS. KABBASH: Objection.

THE WITNESS: This is before the mesh was excised?

BY MR. SLATER:

Q. I don't care. Either before or after.

What did Dr. Smith do to determine whether there was excessive contraction?

A. Well, contraction is something I would assume that you could feel, banding or something underneath the vaginal wall.

So if she said she didn't feel that, that's probably why she made that statement. But you'd have to ask Dr. Smith that to be sure.

Q. Was she asked if she felt banding?

A. She was asked if she felt the contraction -- she said she doesn't feel excessive

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contraction.

Q. Was she asked if she felt banding?

A. Yes, I believe she was. I'd have to go back to the deposition to look at that for sure.

Q. Did Dr. Smith actually inspect the mesh for the purpose of determining whether there was excessive contraction after she explanted it? Did she actually study it for that purpose?

MS. KABBASH: Objection.

THE WITNESS: I'm not sure what she studied in the operating room. You'd have to ask her that.

BY MR. SLATER:

Q. Did you read the IFU when you started using the TVTTM Retropubic?

A. Probably in the very beginning when we first started using it.

Q. Did you believe what you read in the IFU?

A. I don't recall reading the IFU back then as well as I would like to. But I don't recall not thinking that there was something in there that was problematic.

Q. Stress urinary incontinence is not debilitating for all women, is it?

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A. Not for all women, but for many.

MR. SLATER: Move to strike from "but" forward.

BY MR. SLATER:

Q. One thing I forgot to ask you about.

Do you use any Ethicon prolapse devices?

A. I have.

Q. You don't currently?

A. No.

Q. Why not?

A. I used a lot of PROLIFT® when it was out. But I haven't used PROLIFT® since it was discontinued.

Q. Did you use the PROLIFT®+M at all?

A. Yes.

Q. When the PROLIFT®+M came out, did you start to use the PROLIFT®+M rather than the PROLIFT®?

A. I believe I did.

Q. You transitioned to that?

A. I did.

Q. And why did you do that?

A. I can't tell you the exact reason. In the end, I actually didn't see a big difference

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between the meshes. But that's -- that's what we started stocking on the shelves, the PROLIFT®+M.
Q. You don't remember why you transitioned from the PROLIFT® to the PROLIFT®+M?
A. I wanted to try it. And it was very good, so I stuck with it. But in the end, I don't think my outcomes were any different.
Q. Why did you try the PROLIFT®+M? What about it did you think could be a benefit?
A. I liked the idea that it was partially absorbable for prolapse.
Q. Why did you think that was good?
A. I don't know. Less mesh sounded good.
Q. You would agree with me the less mesh you need to use, the better, right?
A. Not necessarily, because I just told you that I didn't see a big difference in my prolapse repairs between using +M and not using +M. It's more of a theoretical thought than anything else that translates into clinical outcomes.
Q. So you didn't think the PROLIFT®+M was any better than the PROLIFT®?
A. No, not in clinical outcomes that I saw. I didn't see a big difference.

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Q. Why don't you use the PROLIFT®+M anymore?
A. That's been discontinued.
Q. Do you know why?
A. You'd have to ask Ethicon that.
Q. You never did?
A. I assume it has something to do with all the medical litigation that's going on.
Q. Did you ever ask them, why are you not selling the PROLIFT®+M anymore, I've been using it with my patients?
MS. KABBASH: Objection.
THE WITNESS: It was very sad, that I could understand.
BY MR. SLATER:
Q. Did you ever ask anyone at Ethicon why they stopped selling the PROLIFT®+M?
A. No, I never specifically asked anyone at Ethicon that question.
MS. KABBASH: I'm going to object to the entire line of questioning.
MR. SLATER: It goes to credibility and bias.
MS. KABBASH: You can say whatever you want about what it goes to, I'm still objecting

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as being beyond the scope.
MR. SLATER: And I'm not going to stop asking it.
MS. KABBASH: It's your time.
BY MR. SLATER:
Q. Do you consider yourself to be an expert with regard to the technical terminology of heavyweight and lightweight mesh, in terms of what is heavyweight and what is lightweight?
A. An expert?
Q. Yes.
A. I'm not a medical materials expert, so no.
- - -
(Whereupon, Exhibit Fleischmann-8, December 2007 E-mails, was marked for identification.)
- - -
BY MR. SLATER:
Q. I've handed you what I've marked as Exhibit-8, which is a couple e-mails from December 2007.
Do you see the bottom e-mail is an e-mail from Jeff Potkul to you?
A. Yes.

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Q. And on December 21, 2007, Mr. Potkul wrote to you and said, I dropped off a holiday gift for you yesterday. Hope all is well and you're enjoying the holiday season. We appreciate your continued commitment to Ethicon women's health and urology.
Do you see that?
A. Yes.
Q. Do you agree that you had a continued commitment to Ethicon?
A. I didn't have a continued commitment to Ethicon. I had a continued commitment to using what I considered to be the best products for my patients.
Q. What was the holiday gift that Jeff Potkul left you?
A. I don't know. I'm very curious. I don't remember it. Maybe it was a box of chocolates.
Q. Mr. Potkul, on December 21, 2007, says, Let me or General know -- and General was your sales rep?
A. Yes.
Q. -- if you require any assistance in completing the grant application General forwarded

to you. If yes, I can get George Callen, my manager, involved, since he has been involved in this process before.

Do you know what that refers to?

A. I don't remember a grant application. It's obviously something that never came through.

Q. Mr. Potkul, in his e-mail to you of December 21, 2007, said, If local advertising is of interest, let me know, since capital is budgeted for it.

Do you see that?

A. Yes.

Q. Do you recall that?

A. Well, now that I see the e-mail. But we never did any local advertisements. I was never involved in anything like that.

It's nice for them to offer, though.

- - -

(Whereupon, Exhibit Fleischmann-9, Co-op Program Funds Advertising Request, was marked for identification.)

- - -

MR. SLATER: Exhibit-9.

BY MR. SLATER:

Q. What I've just given you as Exhibit-9

is a co-op advertising program funds request, which we found in the records that were provided to us. And on the second page it has -- seems to have been filled out for you.

Do you see that?

A. Yes.

Q. Do you recall Ethicon offering to pay for advertising for your medical practice?

A. I guess the reason I don't recall is because we never did any advertising for my medical practice. That's never happened.

Q. You don't recall them talking to you about being willing to help advertise your medical practice?

A. Maybe they did. But it just never came through. We never did it.

Q. You responded to the December 21, 2007, e-mail from Jeff Potkul and said, Thank you for the gift. I inquired about the grant and was told that they did not give grants to individuals, only institutions, so I don't know if that would work for us. Remember, we spoke about PROLIFT® TVT training programs?

Do you see that?

A. This is sort of coming back to me

now.

Q. Good.

A. I think I wanted -- I think I was asking if Ethicon could help contribute to our fellowship program, because we were -- we needed funding for our fellowship program; not to use the products, but because -- but in the end, because I spoke to the institution, that was never going to be art of it.

Q. Ethicon couldn't give funding to the hospitals that you worked at?

A. Right, right. They couldn't.

Q. Why not?

A. Because it's not allowed.

Q. By who?

A. The hospitals.

Q. They won't take money from a medical device manufacturer?

A. No, they won't -- they will not. And that's why.

Q. The hospitals you work with think it unethical to take money from a medical device manufacture?

MS. KABBASH: Objection.

THE WITNESS: It's not that it was

unethical. But we were seeing -- there had been a doctor, I guess, who had -- not from Ethicon, but had gotten some funding, I think, for grants, grant funding for research, and that could be put towards the fellowship program.

It never manifested. It never went anywhere. So that's why that was the case.

BY MR. SLATER:

Q. The hospitals that you worked at would not accept --

A. Monte --

Q. -- funding from a medical device manufacturer, correct?

A. Right.

MS. KABBASH: Dr. Fleischmann, I'm just going to remind you to wait until Mr. Slater gets to the end of his question.

BY MR. SLATER:

Q. You tell Jeff Potkul, Remember we spoke about PROLIFT® TVT training programs.

And there you were talking about wanting to participate in teaching PROLIFT® and TVT to other doctors, right?

A. Yes.

Q. And you understood that Ethicon would

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pay you to do that, right?
A. Right.
- - -
(Whereupon, Exhibit Fleischmann-10, November and December 2008 E-mails, was marked for identification.)
- - -
BY MR. SLATER:
Q. This is Exhibit-10. Some e-mails in November and December of 2008.
And starting out at the bottom, there's an e-mail from Melissa Doyle, northeast professional education manager, at Ethicon, to you, November 28, 2006, right?
A. Yes.
Q. And she's just following up with you to confirm that you're going to be teaching for Ethicon PROLIFT® and TVT, correct?
A. Yes.
Q. And she offers, You can arrive Friday night. If you think you'll be -- Melissa Doyle indicates, you can come in Friday night. You can come out to dinner. She's taking another urologist out for dinner that night.
She offers to take you out to dinner

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that night, right?
A. I guess she did, yes.
Q. And then she talks about to call American Express Travel, and they're going to set up your flight, your car, hotel, and a ride back to the airport Saturday.
Did they take care of all of have for you?
A. I suppose they did.
Q. Do you remember where this lab was?
A. I just -- I'm sorry, I don't have any recollection of this.
Q. You don't recall Ethicon flying you to a training session where you were going to be paid to show other doctors the PROLIFT® and TVT procedure?
A. Back in 2008? I mean, I can see the e-mail there, but I don't -- you know, this is something that happened quite seldom, so I don't remember it, no.
Q. You did participate in that, correct?
A. I believe I did. But I'm just saying that I don't have an independent recollection of the course or, you know, where it was. I'm assuming it happened.

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- - -
(Whereupon, Exhibit Fleischmann-11, March and April 2011 E-mails, was marked for identification.)
- - -
BY MR. SLATER:
Q. Let's look at the next exhibit. This is Exhibit-11. It's some e-mails in March and April of 2012.
And the first one in the chain, which starts at the bottom of the first page is from Michael Dill, a sales representative, to you.
Do you see that?
A. The one that says, I hope the lab? Are you talking about the second page?
Q. Yes, but it starts on the first page. It shows it's from Michael Dill to you, March 30th, 2012?
A. Are we going to --
MS. KABBASH: Yeah, we are. But it's the e-mail itself.
THE WITNESS: Okay.
BY MR. SLATER:
Q. Looking at the Exhibit-11, there's an e-mail at the bottom from Michael Dill, who is a

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sales representative.
Do you remember Michael Dill?
A. No.
Q. Michael Dill wrote to you regarding a dinner with Drs. Fromer, Cooper and Kavaler.
Do you see that?
A. Yes.
Q. Do you know Dr. Fromer?
A. I know her. We trained at the same time in New York. So I know her.
Q. You trained together?
A. No, no. But we were all in the same year in residency.
Q. Are you friendly with Dr. Fromer?
A. I mean, I'm not independent friends with her, but I know her.
Q. Have you talked to Dr. Fromer about the fact that she's also been named as an expert in this case?
A. I was aware of that, but I haven't spoken to her specifically.
Q. Have you talked to her about that she -- the fact that you're both experts in this case?
A. I haven't spoken to her specifically.

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I'm just telling you I'm aware that she's also an expert.
Q. Who is Dr. Cooper?
A. Kim Cooper, she's at Columbia.
Q. And who is Dr. Kavaler?
A. That's Betsy Kavaler.
Q. Do you know her?
A. Yes.
Q. Are you friendly with her?
A. In the same way that I'm friends with Dr. Fromer. I know her, we are colleagues.
Q. Have you ever spoken with Dr. Kavaler about her work as an expert for Ethicon?
A. I know she's that an expert for Ethicon, but I don't talk to her specifically about what she does.
Q. Do you know if Dr. Cooper has been an expert for Ethicon?
A. I don't know.
Q. So Michael Dill, on March 30, 2012, is confirming a dinner with you, Dr. Fromer, Dr. Cooper and Dr. Kavaler.
And do you recall having dinner with them?
A. Not on that date.

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Q. Do you recall that you guys eventually had dinner together?
A. Probably. We've had dinner together in the past.
Q. And at that meeting, three out of the four doctors actually are now Ethicon experts, right, that we can confirm?
A. Looks that way.
Q. You suggested that Dr. Rosenblum be included.
Who is that?
A. She's another colleague.
Q. Do you recall where you guys went to New York -- rephrase.
Do you recall where you guys went to dinner in New York?
A. No, I don't recall.
Q. Ethicon would have paid for that dinner, correct?
A. I assume. If it ever even happened. I don't really recall it specifically.
Q. Well, he's scheduling and he's picking dates there in June, right?
A. I understand that. But I don't recall the specific dinner. So I can't give you any more information about it.
Q. Did you like getting taken out to dinner by Ethicon? Was that fun?
MS. KABBASH: Objection.
THE WITNESS: You know, as a mother of three kids, I have to tell you, I'd rather be home with my kids on almost any date than go out to dinner with people.
MR. SLATER: Move to strike.
BY MR. SLATER:
Q. I'm looking at these e-mails, it looks like you were looking forward to this dinner.
Were you not looking forward to this dinner?
MS. KABBASH: Objection.
THE WITNESS: If I don't recall the dinner, how am I going to tell you if I'm looking forward to it? You're looking at the same e-mail that I am.

- - -

(Whereupon, Exhibit Fleischmann-12, 12/28/09 E-mail from S. Jones to N. Fleischmann, was marked for identification.)

- - -

BY MR. SLATER:

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Q. Handing you Exhibit-12. Exhibit-12, there's an e-mail September 28, 2009 from Scott Jones to you.
Do you see that?
A. Yes.
Q. Scott Jones, who is a marketing executive, invited to you a strategic working session regarding the pelvic floor business.
Do you see that?
A. Yes, I do.
Q. And do you recall attending a strategic working session with Ethicon regarding their pelvic floor business?
A. I recall going to some meetings where we were meeting with other doctors who were using similar products.
Q. And he said he's also going to be inviting the top fifteen PROLIFT® customers to gather for a one-day working session.
Did you know you were one of the top fifteen PROLIFT® customers?
A. I might have been. I really loved PROLIFT®.
Q. He said if you arrived in time, there will be a dinner hosted.

Did you get down there for dinner?
A. Oh, I don't recall, counselor.
Q. It says, you'll attend but arrive the morning of the 5th.
So I guess you would have missed dinner on the 4th, right?
MS. KABBASH: Objection.
THE WITNESS: Possibly.
- - -
(Whereupon, Exhibit Fleischmann-13, 11/6/09 Paper, was marked for identification.)
- - -
BY MR. SLATER:
Q. This is Exhibit-13.
Exhibit-13 is a November 6, 2009, paper you wrote to, Dear Scott.
And just for the record --
MS. CRAWFORD: Can I ask you a question? I don't want to interrupt you. The doctor has indicated she needs to take a break.
MR. SLATER: Okay. Go ahead. I can't stop you.
VIDEO TECHNICIAN: The time is 12:19 p.m. We are going off the record.
- - -

(Whereupon, a brief recess was taken.)
VIDEO TECHNICIAN: The time is 12:24 p.m. Back on the record.
- - -
(Whereupon, Exhibit Fleischmann-14, 11/7/09 E-mail from N. Fleischmann to S. Jones, was marked for identification.)
- - -
BY MR. SLATER:
Q. Doctor, I've handed you Exhibits-13 and 14.
14 is an e-mail you sent to Scott Jones, November 7, 2009, and Exhibit-13 is November 6, 2009 -- it looks like a letter that you wrote to Scott Jones.
So it looks like the e-mail sent the letter; is that correct?
A. I think so, yes.
Q. And you wrote to Scott Jones to follow up on the November 5 meeting because you wanted J&J to understand how one of their most loyal PROLIFT® users came to be that.
You want to tell your story to him, correct?

A. Yes.
Q. I just want to go through certain parts of this.
You say, in the second paragraph, By the time I finished fellowship, I had a strong relationship with the company and, naturally, gravitated to using these products, hence the importance of targeting young fellows.
Do you see that?
A. I do.
Q. So it is true that by the time you finished your fellowship, you had a strong relationship with Ethicon, correct?
A. Not a financial relationship, though.
Q. I didn't ask you that.
Here is my question: You said in your letter to Scott Jones, by the time you finished your fellowship, you had a strong relationship with Ethicon; is that true?
A. I had a relationship to the products. I had been trained on the products, and that was the relationship.
Q. You talk about -- rephrase.
You then comment about the importance of targeting young fellows.

Do you see that?
A. Yes.
Q. When you said "targeting young fellows," you're talking about marketing, right?
A. I probably was, yes.
Q. So you were writing to a marketing director at Ethicon to give him advice on how to market their devices to doctors, right?
A. But that's not what this letter was about. The letter was about something completely different.
MR. SLATER: Move to strike.
BY MR. SLATER:
Q. Turn to the second page.
In the second paragraph, you talk about, the last part of the sentence -- of the paragraph, With the advent of +M, the outcomes are getting better and better.
Do you see that?
A. Yes, I do.
Q. So in your November 6th, 2009, letter to Scott Jones, you're telling him that your outcomes with the PROLIFT®+M were actually getting better and better, right?
A. Yes.

Q. Better and better compared to the PROLIFT®, right?
A. Yes. But this letter was written in 2009, and I did PROLIFT® for about three more years after that. And I'm telling you, I didn't feel in the end, that it was much different.
I also -- yeah, I didn't feel it was much different after the next three years. I had just started using +M at that point.
MR. SLATER: Move to strike from "but" forward.
BY MR. SLATER:
Q. At the end of your letter to Scott Jones, you say, Remember, keeping your loyal users happy is just as important and recruiting new users.
So you're talking about marketing there, right?
A. It looks like it, yes. And that's in response to a marketing meeting that I was coming off of.
- - -
(Whereupon, Exhibit Fleischmann-15, Invoice, was marked for identification.)
- - -
BY MR. SLATER:

Q. I just handed you what I've marked as Exhibit-15.
That's an invoice where you were invoicing Ethicon $2,000 for a preceptorship where you were teaching the TVT-O procedure to doctors on behalf of Ethicon, correct?
A. On behalf of Ethicon? I was teaching TVT-O to doctors. It's very important to me that I teach people properly how to do the device.
Q. You could have taught the TVT-O to doctors without charging any money for that, right?
A. I could have. But it was my time, and why should I -- why should I give my time without being paid for it?
Q. Well, you could have done teaching to doctors outside of Ethicon, professional education; you could have just made yourself available for seven hours and done it separately from Ethicon, right?
A. I have done that. I've done a lot of that in my life.
Q. Okay. You taught for Ethicon and you were paid $2,000 for the preceptorship of June 1, 2009, right?
A. I have an invoice for $2,000, there,

yes. I never looked at it as teaching for Ethicon, though.
- - -
(Whereupon, Exhibit Fleischmann-16, 12/13/08 Invoice, was marked for identification.)
- - -
BY MR. SLATER:
Q. Exhibit-16 is an invoice, December 13, 2008, $2,000, for teaching an advanced Level 2 course.
Do you know what that course was?
A. No, I'm not -- I don't recall exactly.
MR. SLATER: If we want to eat, this is probably a good time.
MS. KABBASH: Okay.
VIDEO TECHNICIAN: The time is 12:29 p.m. We are going off the video.
- - -
(Whereupon, a luncheon recess was taken.)
- - -
VIDEO TECHNICIAN: This marks the beginning of Videotape Number 3. The time is 1:22 p.m. Back on the record.

BY MR. SLATER:
Q. Doctor, I want to ask you some questions about some known complications with the TVTTM Retropubic.
A. Okay.
Q. Would you agree with me that a known complication with the TVTTM Retropubic mesh is chronic pain?
A. I agree that with any pelvic surgery, not specifically with TVT, that is a known complication.
Q. I'm not asking about any other surgeries. So I understand the theme of the defense is all surgeries have these risks.
A. Right.
Q. But I am asking about the TVTTM Retropubic mesh, okay. Which isn't in all surgeries, and I don't really want to talk about other surgeries. I want to talk about this surgery.
A. Okay.
Q. So I'm going to start over.
Would you agree with me that one of the risks with the TVTTM Retropubic is chronic pain?
A. I think that -- I think it is a risk, yes.

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Q. Would you agree with me that one of the known risks with the TVTTM Retropubic is pain with intercourse, which, in some patients, may not resolve?
A. It's a risk. But, again, it's a risk with any pelvic surgery.
MR. SLATER: Move to strike from "but" again -- "but" forward.
BY MR. SLATER:
Q. Doctor, tell me, honestly, I told you in the beginning, if my questions aren't clear, tell me. Are you not clear that I'm asking about the TVTTM Retropubic, because you keep talking about other procedures that I'm not asking you about.
MS. KABBASH: Adam, that's part of her response. And you move to strike it as you want to. There's no point in trying to beat her up over this.
MR. SLATER: I'm not trying to beat anyone up.
MS. KABBASH: She's providing what she believes is an accurate response. Let's just move forward.
MR. SLATER: Don't tell me to move forward. It's not -- you know what, for all the

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time we've worked together -- I didn't ask about other procedures, that's your defense. You guys are entitled to your defense; make your defense at trial. I'm not asking about other procedures.
BY MR. SLATER:
Q. Doctor, if I ask you about other procedures, you can talk about them. I don't want to hear about them. I'm asking about the TVTTM Retropubic. So I'll ask again.
Do you agree with me that with the TVTTM Retropubic mesh device, one risk is chronic pain?
A. I believe that that is a small risk, yes.
MR. SLATER: Move to strike.
BY MR. SLATER:
Q. Did I ask you how large the risk is?
MS. KABBASH: Objection.
BY MR. SLATER:
Q. I mean, was my question unclear? Did you think I asked you how large the risk is?
A. I can answer the question again, if you'd like.
Q. Well, no, I want to know, did you think that I was asking you the size of the risk,

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because if I was, I'll re-ask the question differently.
A. Okay.
Q. Did you think that was what I was asking you?
A. I'm not sure what you asked me. Why don't you ask it again and I'll try to answer it better.
Q. You weren't sure what I asked you just now?
A. Why don't you ask it again, or have them read it back?
Q. For the record, you didn't understand my last question?
MS. KABBASH: Adam, you're getting a little argumentative. Just ask her the question.
BY MR. SLATER:
Q. Doctor, did you not understand my question?
A. I understand your question, but I think I'm allowed to qualify the answer.
Q. Okay. I'm telling you, you're not.
MS. KABBASH: Yes, she is, if she believes it produces an accurate response.
MR. SLATER: I'm going to move to

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preclude testimony at trial if I can't get direct answers to direct questions.
BY MR. SLATER:
Q. Do you agree with me that with the TVTTM Retropubic mesh device, one risk of the mesh being in the body is chronic pain?
A. Yes, in a very small percentage of patients.
MR. SLATER: Move to strike from "in" forward.
BY MR. SLATER:
Q. Doctor, did you think that I asked you how many patients it happens to?
A. No, you didn't ask that.
Q. Do you agree with me that with the TVTTM Retropubic mesh device, that one of the risks is pain with intercourse, which, in some patients, may not resolve?
A. Yes, it can happen.
Q. Do you agree with me that with the TVTTM Retropubic mesh device, one of the risks is neuromuscular problems including acute and/or chronic pain in the groin, thigh, leg, pelvic and/or abdominal area?
A. I'm willing to say that these are

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risks of the procedure, but I really would like to qualify that it is not specific to the TVTTM Retropubic.

MR. SLATER: Move to strike from "but" forward.

BY MR. SLATER:

Q. Do you agree with me that one of the risks with the TVTTM Retropubic mesh device is excessive contraction or shrinkage of the combination of tissue and mesh?

A. I don't know if that's a risk, no. I'm not sure of that.

Q. You don't know one way or the other?

A. I don't know. No, I don't -- I don't know.

Q. Do you agree with me that one of the risks with the TVTTM Retropubic mesh device is that when adverse reactions occur, that may require surgical treatment?

A. Just repeat the question for me, please.

Q. Do you agree with me that with the TVTTM Retropubic mesh device that one of the risks is that if these adverse reactions that you have said you agree occur in some patients, that if they

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occur, that it may require surgical treatment?

A. Yes, that can happen.

Q. Do you agree with me with the TVTTM Retropubic mesh device, that when the adverse reactions occur, one or more revision surgeries may be necessary to treat these adverse reactions?

A. Yes, that can happen.

Q. Do you agree with me that with the TVTTM Retropubic mesh device, in cases in which the PROLENE® mesh needs to be removed, in part or whole, significant dissection might be required?

A. I don't know what you would call significant dissection. I think that you can -- you might need to take out the sling.

Q. So you're not able to answer that?

MS. KABBASH: Objection.

THE WITNESS: I can't say what a significant dissection is. I don't know how to answer that question, because I don't know what significant dissection means.

BY MR. SLATER:

Q. Have you ever seen a warning in connection with any TVT device indicating that in cases in which the PROLENE® mesh needs to be removed, in part or whole, significant dissection

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maybe required?

A. I've seen the warning. But, again, I'm saying I don't know what significant dissection means.

Q. When you say you've seen the warning, you're talking about the warning in the 2015 IFU, right?

A. Yes.

Q. You don't -- you don't understand it, though?

A. I don't -- I think significant dissection needs to be qualified.

Q. So you don't understand what it means?

A. Quantified, I should say.

Q. You don't understand what it means as phrased in the IFU?

A. I understand that significant dissection is not a clear amount of dissection.

Q. So you don't know what it means?

MS. KABBASH: Objection.

THE WITNESS: I think it needs to be quantified.

BY MR. SLATER:

Q. I'm asking you, can you define for me

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what significant dissection means as used in the TVT IFU for 2015?

A. I think it's in an IFU and they are leaving it open for there to be significant dissection. I just don't agree that, necessarily, there's a significant dissection to get out a sling.

Q. How do you define the term significant dissection --

A. I can't.

Q. -- as used in the 2015 TVT IFU?

A. To me, it sounds like a very large dissection, and I don't find that that's necessary, in most cases, to get out a sling.

Q. So you disagree with the warning?

MS. KABBASH: Objection.

THE WITNESS: I don't disagree with the warning. I think the warning leaves open the fact that there might be a significant dissection. I just don't think that's common in my practice, and what I've seen in my practice and what's in the medical literature.

BY MR. SLATER:

Q. Do you know why Ethicon added that adverse reaction to the list in the IFU in 2015?

A. I'm sure it had to do with a lot of

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the medical -- the medicolegal issues that are out there.
Q. You have no idea why they added it, do you?
A. They redid their IFU to add more of the general principles of surgical risk.
Q. Who told you that?
A. That's my own opinion, and that's the opinion that, I think, a lot of us share.
Q. I'm not asking for your opinion here. I'm asking if you factually know why risks were added to the IFU in 2015 for the TVT?
A. I didn't discuss it with anyone at Ethicon, why they -- why they added it to their risks.
Q. So the answer is you don't know, right?
A. The answer is I never discussed it with Ethicon. I can think about why they would have done it. But I don't -- I never discussed it with anyone at Ethicon.
Q. You could speculate as to why it happened, but you don't know?
A. Right.
Q. Do you know what scar plating and

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bridging fibrosis is?
A. Yes, I've been told that scar plating and fibrosis is.
Q. You've been told what it is by who?
A. Through my reading.
Q. Well, where did you read that?
A. In the medical literature.
Q. In connection with your work to get ready to be an expert in this case, is that when you learned what scar plating and bridging fibrosis was?
A. No, I've heard that term well before I became an expert.
Q. What is scar plating and bridging fibrosis?
A. It has to do with the fibrotic reaction that happens when -- mostly when pore sizes are too small and the bridge happens over the pores where the tissue doesn't infiltrate.
Q. Do you agree that scar plating and bridging fibrosis can cause adverse reactions?
A. I don't know that it has a clinical significance.
Q. Do you agree that the clinical manifestation of scar plating and bridging fibrosis can include contraction, pain, erosion, extrusion

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and exposure?
A. I can't agree with that, no.
Q. So if Ethicon says that, you disagree with Ethicon?
MS. KABBASH: Objection.
THE WITNESS: I don't know what Ethicon says about that. I'm just telling you that I don't see how that's related to anything clinical.
BY MR. SLATER:
Q. Here is my question: If Ethicon believes that scar plating and bridging fibrosis can be associated with adverse events and that the clinical manifestation would be contraction, pain, erosion, extrusion and exposure, you would disagree with that?
MS. KABBASH: Objection.
BY MR. SLATER:
Q. Is that what you're saying?
A. I'm saying I would need to see more of the documentation before I respond yes or no to that.
Q. So as you sit here now, you don't know whether or not scar plating and bridging fibrosis can be associated with adverse events and that the clinical manifestation would be

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contraction, pain, erosion, extrusion and exposure?
A. Exactly --
MS. KABBASH: Objection.
THE WITNESS: -- because you're talking about something that's happening on a cellular level, and I don't know how that relates to a clinical outcome.
BY MR. SLATER:
Q. And you've never studied that question, correct?
A. I read about it, but I don't see the correlation in my practice or in any of the medical literature that I've reviewed.
Q. This is my question: Have you actually ever studied that question to try to form an opinion on that question?
A. My opinion is that there's no clinical significance to any kind of scarification that might happen. That is a known process that happens with mesh and one which we actually rely upon.
Q. Is it your testimony that scar plating and bridging fibrosis is something that you rely upon in the use of the mesh?
A. No, scar. Scar. Fibrosis. That's

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the natural reaction of the body to mesh.
Q. I'm asking about scar plating and bridging fibrosis. So let me be very clear.
Have you ever studied the question of whether or not scar plating and bridging fibrosis can be associated with adverse events, the clinical manifestation of which would be contraction, pain, erosion, extrusion and exposure? Have you ever looked at that question to form an opinion?
A. I haven't --
MS. KABBASH: Objection.
THE WITNESS: I haven't studied that question. I can tell you, I don't see scar plating or bridging fibrosis clinically in my patients.
BY MR. SLATER:
Q. Scar plating and bridging fibrosis is something that would be determined by someone specifically looking for it on a histopathological --
A. Exactly. That's my point.
Q. So that's not something you look for, right?
A. I can't look for. It's not something I can see clinically.
Q. If you wanted to, you could have the

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explanted mesh from your patients studied, right?
A. Sure.
Q. You've never done that, right?
A. Well, if I had explanted mesh, it would be sent for pathology, sure.
Q. Have you ever had explanted mesh from your patients studied, on a histopathological basis, to determine whether there was scar plating or bridging fibrosis?
A. Not that I've ordered. It might have happened, but I've never ordered that.
Q. So just to be very clear so we can move on, but I just want to be clear.
Am I correct that you have never studied the question of whether scar plating and bridging fibrosis can cause adverse events, the clinical manifestation of which would be contraction, pain, erosion, extrusion and exposure? Am I correct you have not studied that specific question?
A. I've never studied that on a histopathological level.
Q. Did you read Dr. Klinge's report about that subject?
A. I have, at some point, perused Dr.

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Klinge's report. But I don't -- I can't quote from it.
Q. Did you read any of the published literature on that question?
A. There's not much published literature on that question. It's pretty minimal.
Q. So is the answer you haven't?
A. What's out there, I have reviewed. And I don't give much credence to it.
Q. Do you know if Ethicon gives credence to that literature?
A. I'm not part of Ethicon, so I can't say what Ethicon does.
Q. When Ethicon talks about the complications and the risks from the TVTTM Retropubic device, do you think Ethicon knows what it's talking about?
MS. KABBASH: Objection.
THE WITNESS: In some ways. But Ethicon is not the one that's putting the slings in. We are. We are the ones that see the outcomes and the clinical outcomes.
BY MR. SLATER:
Q. Do you know Peeten Wolf?
A. Not personally.

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Q. Do you know who he is?
A. I've heard his name.
Q. Do you know what he does for a living?
A. I know that he is very high up in Ethicon.
Q. Do you know what department?
A. I can't tell you his exact -- his exact title.
Q. Do you know -- do you know what his background is before he went to Ethicon?
A. I believe he was a urogynecologist.
Q. Do you know if he actually used the TVT in his own clinical practice?
A. It's not -- it's not something that I know or that affects how I think or what my opinions are about this case.
Q. I just want to know, do you know if Peeten Wolf used the TVT device?
A. I'm not sure. I can't -- I can't answer that question.
Q. Do you know who Dr. Jim Hart is?
A. No.
Q. Never heard of him?
A. Nope.

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Q. In your report, your main report --
A. My general report?
Q. Your general report.
-- you talk about the Cochrane review by Ogah, O-G-A-H, et al.
Is that an important article for you in forming your opinions in this case?
A. It's one of the articles that I've relied upon.
Q. Did you read it carefully?
A. I read it carefully at some point, not recently.
Q. You talk about that article on Pages 18 and 19 of your general report.
A. Okay.
Q. Do you feel that your summary of what that article stands for is a fair summary of the important conclusions and findings by the authors?
A. Yes.
Q. Do you feel that you were obligated, as an expert, when you wrote your report, to try to be fair and balanced in describing that article, so that you would not just point out things that might support Ethicon's position but also things that may cut against?

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Did you try to do that?
MS. KABBASH: Objection.
THE WITNESS: Yes, I tried to do that.
BY MR. SLATER:
Q. On Page 20, if you could turn to Page 20, you talk about the American Urologic Association guidelines.
And towards the bottom of that first paragraph, you say, In the case of TVT, there is an added complication of mesh exposure.
Do you see you said that?
A. Yes, I did say that.
Q. There are additional complications with the TVT as compared to non-mesh procedures, correct?
A. Like what?
Q. How about contraction of the mesh causing pain?
A. I don't think that I can say that that's a definite complication of TVT.
Q. It's your position, testifying as an expert for Ethicon, that contraction of the mesh due to the interrelationship of scar tissue in the mesh cannot cause pain for a patient?

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A. Not by that process, no.
MS. KABBASH: Objection.
BY MR. SLATER:
Q. If one needs to remove mesh due to a complication, the removal of the mesh is now a surgery that is necessary as a result of the mesh problem, right?
MS. KABBASH: Objection.
THE WITNESS: It's a revision of a sling, yes.
BY MR. SLATER:
Q. If there's no mesh, that surgery would not need to happen, because you wouldn't be removing mesh, right?
MS. KABBASH: Objection.
THE WITNESS: You wouldn't be removing mesh, but you might need to do another revision surgery for another sling procedure or another anti-incontinence procedure.
MR. SLATER: Move to strike from "but" forward.
BY MR. SLATER:
Q. When we're talking about the TVTTM Retropubic, and what the mesh can cause, one of the things the mesh can lead to is the need to remove

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the mesh, right?
A. You might need to remove mesh, yes.
MS. KABBASH: Objection.
BY MR. SLATER:
Q. If there's no mesh, you don't have to remove mesh, by definition, right?
A. No, but --
MS. KABBASH: Objection.
THE WITNESS: -- you might need to do something else.
MR. SLATER: Move to strike from "but" forward.
BY MR. SLATER:
Q. Was that funny?
A. No. I'm just trying to clarify what I'm saying.
Q. Mrs. Corbet had options other than the TVTTM Retropubic, correct?
A. Yes.
Q. You can't tell me what would have happened if Mrs. Corbet had a different procedure or different type of treatment? That would be speculative to say, well, if she had something else let tell me what happened; you can't say, right?
MS. KABBASH: Objection.

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THE WITNESS: I can't say. But I can -- I can tell you what the risks of another surgery would have been.
BY MR. SLATER:
Q. I understand you know the general risks of other surgeries.
But you can't say whether or not they would have happened, right?
A. You can't say whether a risk ever would have happened. That's what a risk is.
Q. Can you turn to Page 25 --
A. Sure.
Q. -- of your report?
The first full paragraph, you say, While several authors have reported on their experience with mesh exposure, there is currently no evidence-based consensus on exactly how to manage exposures.
Right?
A. Yes.
Q. Do you stand by that statement?
A. Yes.
Q. At the end of that paragraph, you say, In my experience, removing the extruded mesh almost always resolves the patient's exposure

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problem.
That's what you're seeing in your experience, right?
A. That's in my experience. But I think that's also in the literature.
Q. You say, almost always resolves the problem.
So sometimes removing the extruded mesh does not resolve the patient's problem, right?
A. It depends on what the problem is.
Q. You called it the exposure problem, right? Isn't that the words you used?
A. Yes.
Q. So removing the extruded mesh does not always resolve the patient's exposure problem, correct?
A. In my experience, it's pretty superlative, when you take out an exposed area of a sling, that that sling exposure is resolved.
Q. Doctor, you use the words "almost always." So my question is: In your experience, removing the extruded mesh does not always resolve the patient's exposure problems; sometimes it doesn't, correct?
A. Sometimes it doesn't. But it would

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be extremely rare.
MR. SLATER: Move to strike from "but" forward.
BY MR. SLATER:
Q. Turn to Page 26 of your report, if you could.
You talk during your report -- in your report, about degradation of mesh. Have you ever studied the question of whether or not the mesh in the TVTTM Retropubic degrades on any level, whether a macro level or a micro level?
A. I've read the literature about degradation. I find it's pretty scant.
Q. Have you ever looked at Ethicon's internal documents regarding degradation of PROLENE® mesh?
A. I've reviewed some of them in preparation for this deposition, yes.
Q. Did the people who showed you Ethicon documents show you any of the internal documents that show that degradation of PROLENE® mesh occurs? Did you see those documents?
A. I didn't find anywhere that there was degradation of mesh that had occurred.
Q. So whatever you were provided from

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Ethicon's documents, you weren't provided those documents, were you?
MS. KABBASH: Objection.
THE WITNESS: I think if those documents had existed, they might have provided them to me.
BY MR. SLATER:
Q. Meaning you would expect you would have been given them, if they existed, right?
A. Yes.
Q. I have a question about the TVT EXACT®® -- rephrase.
With the TVT EXACT®®®, it's the same mesh, the same size mesh as with the TVTTM Retropubic, and you said the difference is just the insertion with the trocars, and it's inserted a little bit differently?
A. Well, it depends. I think the TVT EXACT®®® is more the laser cut mesh, whereas the retropubic TVT that I was using years ago was a mechanical cut mesh.
Q. The mesh in the TVT EXACT®®® is laser cut?
A. I think so, yes.
Q. The TVTTM Retropubic mesh that you

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used was machine cut, correct?
A. Yes.
Q. Are you happy with the performance of the laser cut mesh?
A. I don't really see a difference.
MR. SLATER: Move to strike.
BY MR. SLATER:
Q. Are you happy with the performance of the laser cut mesh?
A. Yes. Because I don't really see a difference from what I was doing before.
Q. I'm sorry, did I ask you if there was a difference?
A. No, you didn't.
Q. Why would you tell me that, then?
A. I don't know. I felt a need to qualify it.
Q. I can -- I hope you don't expect to do that at trial.
MS. KABBASH: Objection.
Don't answer that.
BY MR. SLATER:
Q. Doctor, with the TVT EXACT®®®, are you satisfied with the performance of that mesh?
A. Yes.

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Q. Is the TVTTM Obturator offered in the laser cut mesh?
A. I believe it is, but I haven't used it.
Q. Did Ethicon actively market the existence of the laser cut mesh to physicians?
A. I don't know.
MS. KABBASH: Objection.
THE WITNESS: They didn't market it to me. And I don't know what they did in the outside world.
BY MR. SLATER:
Q. Did Ethicon provide you any internal documents showing that they believed laser cut mesh had advantages over machine cut mesh?
MS. KABBASH: Objection.
THE WITNESS: I saw some documents of some e-mails about laser cut mesh. I didn't see any evidence-based medicine that showed that laser cut mesh was superior.
BY MR. SLATER:
Q. Did you see any internal documents from Ethicon indicating that anyone within Ethicon thought that there were advantages to the laser cut mesh over the machine cut mesh?

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A. I saw some internal documents about conjecture of whether laser cut mesh would be better than mechanical cut mesh.
Q. Do you have an understanding as to whether or not Ethicon thinks there are some advantages to laser cut mesh over mechanical cut?
A. It doesn't really matter to me if Ethicon thinks about laser or mechanical cut mesh.
Q. I'm just asking if you know whether or not Ethicon believes there's a benefit to the laser cut mesh over the mechanical cut mesh. Do you know?
A. I don't know what Ethicon believes, no.
Q. Do you dispute that particle loss occurs with mechanical mesh?
A. I think it occurs, yes.
Q. You wouldn't dispute that particles of the mesh with a mechanical cut TVTTM Retropubic can get into the body during implant? You don't dispute that, right?
A. I would dispute that it gets into the body at large. I think that particles can come off of the mesh in a local area.
Q. A local area, in --

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A. That you're working in.
Q. -- the surgical field?
A. In the surgical field, yes.
Q. Do you know what the particles of mesh that come off the machine cut mesh will do once in the body?
A. I believe they have no clinical significance.
MR. SLATER: Move to strike.
BY MR. SLATER:
Q. Do you know what the particles of mesh will do when inside the body?
MS. KABBASH: Objection.
THE WITNESS: Yes, they will do nothing.
BY MR. SLATER:
Q. That's your understanding?
A. Yes.
Q. The particles of mesh would be a foreign body inside the body, right?
A. Yes, because it's not the patient's own body.
Q. You would expect there to be a foreign body reaction to the particles of mesh, correct?

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A. Possibly, but it wouldn't have any clinical significance.
MR. SLATER: Move to strike from "but" forward.
BY MR. SLATER:
Q. Have you ever studied the question of whether or not particles of mesh from a TVTTM Retropubic that get into the body cause a foreign body reaction and any clinical issues with the patient? Have you ever studied that?
A. I've studied it in the 1,500 or more slings that I have placed, which have all been mechanically cut mesh.
Q. Tell me how you studied the impact of particles.
A. I've studied it because I've seen no clinical significance to these -- to these -- to this so-called particle loss that you're talking about.
Q. And what would you be looking for to determine that there's clinical significance? What were you looking for?
A. Anything.
Q. Did you ever actually look to see if there were particles in the body of any of your

Page 211

patients and whether they caused an issue for the patient? Did you ever look for that?
A. Well, I don't know how I could look at that, because that would be ethically opening up a patient again.
Q. I just want to know if you've ever done it.
A. No, there's been no reason to do it.
MR. SLATER: Move to strike after "no."
BY MR. SLATER:
Q. One of your articles in your list of publications is "Pelvic Floor Reconstruction, State of the Art and Beyond."
What's the journal that that was published in?
A. This is the article I published in my fellowship. The Urology Clinics of North America.
Q. Is that -- what level journal is that considered to be?
A. I'm not sure.
Q. That wouldn't be considered to be a Level 1 medical journal, would it?
A. I don't know the answer to that.
Q. What --

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A. It is a peer-reviewed article, it's a peer-reviewed journal.
Q. What was the article about?
A. Oh, boy. We're talking about 11 years ago.
I think we were just talking about slings and, possibly, prolapse in here. But I haven't reviewed it in a long time.
Q. You don't recall what you said there?
A. I would need to look at the article, if I could. I would be happy to.
Q. I'm just curious -- you wrote it.
I'm just curious if you know what you said in the article?
A. I don't recall exactly.
Q. In looking at your publications, it looks like the first four on list, from 2002, 2003, 2004 and 2004, would have all been during your fellowship, correct?
A. No. The first two were during my residency.
Q. Ah, residency?
A. Yeah. That's when I was in the lab.
Q. Looking at your publications, the first two, from 2002 and 2003, would be from your

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residency, correct?
A. Correct.
Q. The articles from 2004 would be from your fellowship, correct?
A. Exactly.
Q. You have an article listed here, "Vaginal Approach to Postsurgical Bladder Outlet Obstruction." And that was printed what, in a textbook?
A. Yes. Dr. Zimmern?
Q. When was that -- when was that published? Was that from your fellowship?
A. Yeah, that was also from my fellowship.
Q. Who is Dr. Nitti?
A. Dr. Nitti was my mentor in my fellowship.
Q. Did Dr. Nitti have any affiliation with any medical device manufacturers?
A. Possibly.
Q. Do you know which?
A. I don't know, but I know that he probably did.
Q. There's an article, Fleischmann, Nitti, et al., "Voiding Dysfunction and Urinary

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Retention." It looks like it was published in 2007 in a text.

But that was also written during your fellowship, correct?

A. No. That was probably something I reviewed later on in 2007. I was already out in practice.

Q. So you were co-authors with Dr. Nitti?

A. Yes.

Q. Did you write that? Is it -- what is it?

A. It was a chapter in a book.

Q. The last article you have there is a chapter or is it -- it's actually an article in Obstetrics and Gynecology Survey, is that?

A. Yes.

Q. What's that?

A. It's just a -- it's a journal.

Q. Is it a high-level journal?

A. It's a peer-reviewed journal.

Q. I know. Is it a high-level journal?

A. I don't know how to qualify that.

MS. KABBASH: Objection.

BY MR. SLATER:

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Q. Do you know the difference between the high-level journals and the lower-level journals?

A. I believe I do.

Q. Is this -- where does this one fall on the spectrum?

A. I don't -- I don't know where this journal falls on the spectrum.

Q. Do any of your publications relate to the treatment of stress urinary incontinence?

A. That would -- in the third and fourth -- probably the first -- after the ovariectomy one, the next five all related to incontinence.

Q. Do any of your articles address potential risks with the TVTTM Retropubic or any other synthetic mid-urethral sling?

A. I have to look at these articles. I haven't looked at them in a while. But I'm sure, at least in the 2004 articles, they would have been addressed, yes.

Q. I'm looking, now, at your report that we marked as Exhibit-6, your supplemental report in this case.

A. Okay.

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Q. And on Page 19, I have a question for you.

A. Sure.

Q. On Page 19, you talk about roping and curling.

Are you denying that roping and curling of TVTTM Retropubic mesh can occur in some women?

A. I think it can occur, yes.

Q. So you agree that roping and curling of TVTTM Retropubic mesh can occur in some women, correct?

A. In specific instances it can occur, yes. When there's a lot of deforming tension placed on the mesh, you can see roping and curling.

Q. Deforming tension is enough tension to be placed on the mesh to cause the mesh to deform its shape?

A. It's usually a surgical technical problem.

Q. When you say a "problem," you mean it's a surgical or technical cause?

A. Yes.

Q. So let me ask you this: There's no objective measurable way to determine whether the

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right amount of tension is being placed on the mesh when it's placed, that's just a matter of feel and experience, correct?

A. No, it's pretty clear. You're supposed to be placing these loosely.

Q. What does that mean, "loosely"?

A. Well, it's a tension-free device, which means that you're not supposed to put tension on the mesh when you place it.

Q. Is tension placed on the TVT mesh when it's placed in the body?

A. It is, if it's not placed properly and carefully, and that's part of what our training is about.

Q. A doctor can follow the TVTTM Retropubic procedure and still place tension on the mesh during the insertion process, correct?

A. Sometimes inadvertently they can do it, if they're not being careful.

Q. When mesh is -- rephrase.

When tension is placed on the TVTTM Retropubic mesh during implantation, that can deform the mesh, correct?

A. Yes, it could. If you put too much tension on when you're placing it you can cause

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deformation.
MR. SLATER: Move to strike from "if" forward.
BY MR. SLATER:
Q. When tension is placed on the TVTTM Retropubic mesh, that can cause the mesh to rope and curl, correct?
A. Yeah, I think it could, yes.
Q. Did you ever see Ethicon warn doctors about roping and curling of the mesh as a result of tension? Did you see a warning to that effect in the IFU or somewhere else?
A. The IFU does warn about putting too much tension on mesh. It talks about it in the IFU.
Q. Does it -- does the IFU point to the risk that if tension is placed on the mesh, that can lead to roping and curling of the mesh? Does it say that?
A. No, it doesn't say roping and curling specifically, but it talks about over tensioning of the mesh being a warning.
Q. The IFU says that too much tension applied to the tape may cause temporary or permanent lower urinary tract obstruction; that what you're referring to?

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A. Yes.
Q. It says -- the IFU says nothing about the risk that tension on the mesh can lead to roping or curling?
A. It doesn't say roping or curling in the IFU.
Q. Have you had roping or curling of mesh that you -- of TVTTM Retropubic mesh that you've put in women's bodies?
A. I can't recall a specific case where I've seen, in my patients, roping and curling.
Q. You've seen roping and curling of TVTTM Retropubic mesh that was placed by other doctors?
A. I have. I've seen the mesh get banded into a tight rope. And that's -- and that's just when there's too much tension placed on it.
Q. When the mesh is placed -- actually, let me just check something.
When the mesh is placed, if a cough test is performed during the procedure, what should the surgeon be looking for?
A. If you do it that way, you should be looking for just a little bit of leakage with a -- with a cough.

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Q. If there's no leakage, that would mean it's too tight, right?
A. No, not necessarily.
Q. If there's no leakage -- well, rephrase.
The reason you want to see a little leakage is because there's going to be some contraction and you don't want it to be too much and then cause an obstruction, right?
A. Yes. But you know something, I think that it's really the surgeon's prerogative how to tension it. There is an art more than a science to this. So we don't go by IFUs when we talk about sling tensioning; that's something we learn in our practice, in our fellowship, in our training, in our experience with doing these slings.
So I personally don't do cough tests.
MR. SLATER: Move to strike after "yes."
BY MR. SLATER:
Q. Other than your work in this case, reading documents in connection with this case, were you familiar with the concept of cytotoxicity?
A. No. I mean, not specifically with TVT. I've heard the word cytotoxicity before, but

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not in relation to the sling.
Q. You're not -- you're not offering opinions -- rephrase.
You're not proposing to offer expert opinions regarding cytotoxicity in this case, are you?
A. I'm not a histopathologist, so no.
MR. SLATER: I don't have any other questions.
- - -
(Whereupon, a discussion off the record occurred.)
- - -
VIDEO TECHNICIAN: The time is 2:04 p.m. Going off the record.
- - -
(Whereupon, a discussion off the record occurred.)
- - -
VIDEO TECHNICIAN: The time is 2:08 p.m. We are back on the record.
- - -
EXAMINATION
- - -
BY MS. KABBASH:

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Q. Dr. Fleischmann, I have some questions to ask you.
You were asked several questions today regarding your opinions, in the Corbet case, regarding the adequacy of the TVTTM Retropubic warnings.
Do you recall that?
A. Yes.
Q. And you have -- am I correct that you have offered the opinions in your expert report, and here today, that the TVT warnings that were in place at the time of Mrs. Corbet's surgery were adequate, correct?
MR. SLATER: Objection to the form of the question. Leading. I object to all leading questions. I'll continue to say object to the form every time. It's inadmissible to question your own expert that way here.
MS. KABBASH: You can answer.
THE WITNESS: Yes, I believe the warnings are adequate.
- - -
(Whereupon, a discussion off the record occurred.)
- - -

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BY MS. KABBASH:
Q. Dr. Fleischmann, what is your opinion on the adequacy of the TVT warnings based on? What sources of information?
A. I base my opinion on my experience, on my review of the medical records, my training, and everything I've seen regarding TVT, that these warnings were adequate.
Q. In terms of what you've seen regarding TVT, does that include medical literature?
A. Yes.
Q. And can you tell me a bit about the body of medical literature that has informed your opinion about the adequacy of TVT's warnings?
MR. SLATER: Objection.
You can answer.
THE WITNESS: I reviewed a lot of literature over the last several months, and even since the beginning of my career. And there is definitely Level 1 systematic reviews that talk about the risks associated with TVT, and these are adequately addressed in the warnings.
BY MS. KABBASH:
Q. You testified -- strike that.
Does your opinion that the TVT warnings are adequate mean that they are adequate only for you personally?
MR. SLATER: Objection.
THE WITNESS: No. The warnings are adequate for any trained person who is placing the TVT.
BY MS. KABBASH:
Q. Do you believe that the TVT warnings in place at the time of Mrs. Corbet's surgery were adequate for the medical community of doctors who do pelvic floor surgery to treat stress urinary incontinence?
A. Yes.
MR. SLATER: Objection.
THE WITNESS: Yes.
BY MS. KABBASH:
Q. And, Doctor, you were asked some questions about TVT EXACT®®®.
Do you currently use TVT EXACT®®®?
A. Yes, I have.
Q. Is TVT EXACT®®® a retropubic approach of sling to treat SUI?
A. Yes, it is.
Q. Does -- do the trocars in TVT EXACT®®® travel the same anatomical path as the trocars in

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TVTTM Retropubic?
A. The exact same place.
Q. Is it your current intention to continue to use TVT EXACT®®® in the future, in patients for whom you believe it is appropriate?
MR. SLATER: Objection.
THE WITNESS: Absolutely.
BY MS. KABBASH:
Q. Is the mesh sling of the TVT EXACT®®®, other than being laser cut, the same as the mesh sling in TVTTM Retropubic?
A. Yes, it's the same.
Q. And have you noticed any difference in the clinical outcomes between your patients who have had TVT EXACT®®® versus your patients who have had TVTTM Retropubic?
A. No, I haven't.
Q. Did the fact that TVT EXACT®®® uses a laser cut mesh sling play any role whatsoever in your decision to use TVT EXACT®®®?
A. No. In fact, I'm not even sure I knew that it was a laser cut mesh when I first started using it.
Q. Do you continue to use TVT-O today?
A. Yes, I do.

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Q. And does the version of TVT-O that you use today have a mechanical cut sling or a laser cut sling?
A. We still have the mechanical cut sling on our shelves.
Q. And that's what you use?
A. Yes, I like it.
Q. Do you have any current intention to switch from a mechanical cut sling to a laser cut sling for your use of TVT-O?
A. No, I don't.
Q. Did you begin to use the TVT-O because you thought TVTTM Retropubic was unsafe?
A. I didn't think it was unsafe. I just preferred the risks of the TVT-O versus the risks of the TVT-R.
Q. And do you -- do you believe that a choice of TVTTM Retropubic or TVT-O can be a matter of surgeon preference in many cases?
MR. SLATER: Objection.
THE WITNESS: Absolutely. Because I still use the TVTTM Retropubic.
BY MS. KABBASH:
Q. And do you consider -- when you chose to use TVT-O, was that a matter of surgeon

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preference for you?
MR. SLATER: Objection.
THE WITNESS: I found the device easy to use in my hands. It was -- remember, I'm training a lot of residents and fellows, and I know that, initially with training, you have much higher risks of bladder injuries. And I just felt that, in my hands and in training, it was -- it was more beneficial to the patients to have a TVTTM Obturator.
BY MS. KABBASH:
Q. And the risk of bladder injuries, is that warned of in the TVT warnings that were in place at the time of Kathryn Corbet's surgery?
A. Absolutely warned about.
MR. SLATER: Objection.
BY MS. KABBASH:
Q. And the does the risk of bladder injuries exist for any sling to treat SUI that has a retropubic approach?
MR. SLATER: Objection.
THE WITNESS: Absolutely.
BY MS. KABBASH:
Q. And that includes TVT EXACT®®®?
A. It includes TVT EXACT®®®. It includes

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pubovaginal sling. It includes Burch colposuspension.
Q. Dr. Fleischmann, you were asked some questions earlier today about foreign body reaction and the February 2013 pathology report that was issued by the hospital following Dr. Smith's revision of Ms. Corbet's sling.
Do you recall that?
A. Yes.
Q. Did you also, in your review of the records, have occasion to see the pathology report from July 2011 that accompanied Dr. Harrell's initial implant surgery?
MR. SLATER: Objection.
THE WITNESS: I did review his pathology report.
BY MS. KABBASH:
Q. And did that pathology report address tissue that had been removed from Mrs. Corbet before her TVT implant was done?
MR. SLATER: Objection.
THE WITNESS: Yes, it did.
BY MS. KABBASH:
Q. Does that report refer to chronic inflammation?

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MR. SLATER: Objection.
THE WITNESS: I recall that it did, which is normal in vaginal tissue, to see chronic inflammation.
BY MS. KABBASH:
Q. And why is that?
A. Because vaginal tissue is exposed to the outside world, and it can become chronically inflamed.
Q. Dr. Fleischmann, are you aware of any sling material that eliminates or even reduces the risk of vaginal exposure?
MR. SLATER: Objection.
THE WITNESS: I'm not aware of any sling material that will reduce the risk of vaginal exposure or any exposure.
BY MS. KABBASH:
Q. Are you aware of any sling material that eliminates or even reduces the risk of vaginal scarring?
MR. SLATER: Objection.
THE WITNESS: No.
BY MS. KABBASH:
Q. Are you aware of any sling material that eliminates or even reduces the risk of urge

incontinence?
A. No, I'm not.
Q. Are you aware of any sling material that eliminates or even reduces the risk of urinary frequency?
MR. SLATER: Objection.
THE WITNESS: No.
BY MS. KABBASH:
Q. Are you aware of any sling material that eliminates or even reduces the risk of hematoma?
MR. SLATER: Objection.
THE WITNESS: Not material. I think that when you place the device as in an obturator approach, there's much less of a risk of a hematoma. But any -- any sling that's placed in a retropubic space can develop a hematoma.
BY MS. KABBASH:
Q. Are you aware of any sling material that reduces or eliminates the risk of pain with sexual intercourse?
MR. SLATER: Objection.
THE WITNESS: No.
BY MS. KABBASH:
Q. Dr. Fleischmann, plaintiffs' counsel

asked you a series of questions before about a series of risks and whether they are a risk of TVT, and I'll just -- I'll list them as best we can.
One was chronic pain; another was dyspareunia that, in some patients will not resolve; another was regarding neuromuscular problems, and it went into further detail; another was excessive contraction or shrinkage of the mesh; another was that the risk may require surgical treatment, and that revision surgery may happen; and I believe the last one was that significant dissection might be required.
Do you recall that line of questioning by plaintiffs' counsel?
A. Yes, I do.
Q. Dr. Fleischmann, is it your opinion that Ethicon needs to warn doctors of those risks, as plaintiffs' counsel worded them, so that their warnings will be adequate?
MR. SLATER: Objection.
THE WITNESS: I don't believe that it is needed.
BY MS. KABBASH:
Q. And why is that?
A. Because I think these are the risks

that pelvic surgeons know, trained pelvic surgeons know, when placing slings or doing any kind of pelvic surgery.
Q. Do you believe that these risks are common knowledge to the body of surgeons who are pelvic floor surgeons who treat stress urinary incontinence?
MR. SLATER: Objection.
THE WITNESS: Absolutely.
BY MS. KABBASH:
Q. Do you believe that several of these risks are risks of general pelvic surgery as opposed to specifically related to a device?
MR. SLATER: Objection.
THE WITNESS: Absolutely.
BY MS. KABBASH:
Q. Doctor, based on your experience and your review of the medical literature, have you seen evidence that roping or curling of mesh slings happened in the absence of a doctor putting too much tension on the mesh?
MR. SLATER: Objection.
THE WITNESS: No, I haven't.
BY MS. KABBASH:
Q. Dr. Fleischmann, plaintiffs' counsel

asked you before whether it would be, and I believe he used the word speculative, to say that certain risks would happen if other surgery had been used on Mrs. Corbet.
Do you recall that line of questioning?
A. Yes, I do.
Q. Even though you cannot say for sure whether a risk will happen, does the potential that risks could happen, is that relevant to a doctor's recommendation of what the appropriate treatment would be?
MR. SLATER: Objection.
THE WITNESS: Yes, because we need to discuss all of the risks and benefits with our patients so that we can make an informed decision. And there is no procedure that does not involve risk.
MS. KABBASH: I don't have any other questions at this time. He might have a few more.
- - -
EXAMINATION
- - -
BY MR. SLATER:
Q. The TVT-O, the insertion and the

trocars, takes a different path than with the TVTTM Retropubic, correct?
A. Yes.
Q. And different from the TVT EXACT®®®, correct?
A. Yes. Those are both retropubic slings, and the obturator goes to the obturator space.
Q. With regard to the warnings, is it fair to say that you have no information whatsoever as to what a medical device manufacturer, or even Ethicon in specific, is required to do in providing warnings?
MS. KABBASH: Objection.
THE WITNESS: No, I have a lot of ideas of what a medical device manufacturer is supposed to do.
BY MR. SLATER:
Q. I understand you may have ideas.
But you have no knowledge of any standards or criteria that are applicable to a medical device manufacturer, like Ethicon, in providing warnings, correct?
MS. KABBASH: Objection.
THE WITNESS: I think I do have an

idea of the standards. They are supposed to discuss the risks of the procedure that are specific to that device.
MR. SLATER: I have no other questions.
- -
VIDEO TECHNICIAN: This marks the end of today's deposition. The time is 2:21 p.m. We are going off the record.
- - -
(Whereupon, the deposition was concluded at 2:21 p.m.)
- - -

CERTIFICATE

I HEREBY CERTIFY that the witness was duly sworn by me and that the deposition is a true record of the testimony given by the witness.

Amanda Maslynsky-Miller
Certified Realtime Reporter
Dated: November 25, 2015

(The foregoing certification of this transcript does not apply to any reproduction of the same by any means, unless under the direct control and/or supervision of the certifying reporter.)

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ACKNOWLEDGMENT OF DEPONENT

I,_____, do hereby certify that I have read the foregoing pages, and that the same is a correct transcription of the answers given by me to the questions therein propounded, except for the corrections or changes in form or substance, if any, noted in the attached Errata Sheet.

_____

NICOLE FLEISHMANN, M.D. DATE

Subscribed and sworn to before me this _____ day of _____, 20____.

My commission expires:_____

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Notary Public

LAWYER'S NOTES

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